Summary Plan Description

IMPORTANT BENEFITS INFORMATION

AT&T Flexible Spending Account Plan

This Summary Plan Description (SPD) is a guide for using the AT&T Flexible Spending Account Plan (Plan).

Please keep this SPD for future reference.

DISTRIBUTION: Distributed to active Employees of AT&T Companies listed in the "Participating Companies and Applicable Collective Bargaining Agreements" Appendix A of the SPD who may be eligible to participate as described in the "Eligibility and Participation" section of the SPD.

NIN: 78-41171

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 summary plan description (SPD) is a guide to using the AT&T Flexible Spending Account Plan (Plan) and constitutes the Plan document.

This SPD contains a summary in English of your plan rights and benefits under the AT&T Flexible Spending Account Plan. If you have difficulty understanding any part of this booklet, please contact the AT&T Benefits Center at **877-722-0020**, between 7 a.m. and 7 p.m. Central time Monday through Friday.

Este SPD contiene un resumen, en ingles, al AT&T Flexible Spending Account Plan. Si usted tiene dificultad en entender este documento, entre en contacto por favor con el AT&T Benefits Center en **877-722-0020**, entre 7 a.m. and 7 p.m. CST, Lunes a Viernes.

Why Did I Receive This Document?

You may be eligible to participate in the AT&T Flexible Spending Account Plan as described in this SPD.

What Action Do I Need to Take?

Please review this document carefully for detailed information about the Plan provisions and keep it for future reference.

How Do I Use This Document?

It is important that you read this SPD to get a complete picture of the Plan provisions that may apply to you, including:

- Before-Tax Premium Option
- Health Savings Account Payroll Contributions
- Health Savings Account Company Contributions
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

Questions?

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

HIGHLIGHTS

This SPD describes benefits under the Plan as of Jan. 1, 2018. Changes since the last SPD, including changes previously communicated through Summaries of Material Modification (SMMs), are incorporated. While you should review the entire SPD, please note the following list of important changes:

- Increase the Health Care Flexible Spending Account contribution cap to $2,600 for managers and certain Bargained Employees effective Jan. 1, 2018, as provided in "Appendix B" *Eligibility, Enrollment, Eligibility Waiting Period, And Contribution Limits Matrix*;
- Increase in the Health Savings Account (HSA) contribution cap for 2018 to $3,450 for individual coverage and $6,900 for family coverage, per Internal Revenue Service regulations;
- Update the Company contribution to the Health Savings Account for certain Eligible Employees, see the "Health Savings Account Company Contributions" section for more information;
- Adding a new Claims Administrator, Your Spending Account, for the Health Care and Dependent Care flexible spending account options. See the *Claims Administrator* table in the "Contact Information" section for contact information;
- Modifying the way Healthcare and Dependent Care Flexible Spending Account Claims can be paid; and
- Update the list of Participating Companies and Bargaining Units. See "Appendix A" *Participating Companies and Applicable Collective Bargaining Agreements* for more information.

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

- *The AT&T Flexible Spending Account Plan provides before-tax benefits to Eligible Employees of Participating Companies.*
- *This summary plan description (SPD) is a guide to using the AT&T Flexible Spending Account Plan (Plan) and constitutes the Plan document, effective Jan. 1, 2018.*
- *This SPD provides information regarding eligibility and benefits under the Plan for Active Employees of the Participating Companies.*
- *Many sections of this SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. So, it is important that you review all sections that apply to a specific topic.*
- *Please review this SPD. This SPD replaces information in other documents, like Annual Enrollment Materials and the Where to Go for More Information, and summaries of material modification (SMMs) to the extent those documents describe plan provisions.*

This summary plan description (SPD) is a guide to using the AT&T Flexible Spending Account Plan (Plan) and constitutes the Plan document, effective Jan. 1, 2018. The Plan was first established on Jan. 1, 1990, and has been amended since that time.

This SPD provides information regarding eligibility and benefits under the Plan for Active Employees of the Participating Companies listed in "Appendix A" *Participating Companies and Applicable Collective Bargaining Agreements*. See the "Eligibility and Participation" section for information on your eligibility to participate in the Plan. "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limits Matrix* provides important information about when you can enroll and how much you can contribute.

This SPD provides information about the following benefits for Eligible Employees:

- Before-Tax Premium Option
- Health Savings Account Payroll Contributions
- Health Savings Account Company Contributions
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

This SPD does not provide information about Health Reimbursement Accounts (HRAs), which are Company-funded accounts that can be used by Eligible Employees to reimburse themselves for eligible medical expenses. For more information, refer to the HRA Summary Plan Description.

Understanding what the Plan offers will help you take advantage of the benefits it provides and make the most of your total compensation package.

Many sections of this SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. So, it is important that you review all sections that apply to a specific topic. In addition, footnotes and notes imbedded in the text are used throughout this SPD where needed to provide clarification or additional information or to identify an exception or other distinction. These notes provide information that is important to fully understand the Plan and the benefits it provides.

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 in this SPD.

Plan refers to the AT&T Flexible Spending Account Plan described in this SPD.

Company Labels and Employee Group Acronyms Used in This SPD

Not all information in this SPD applies to every Eligible Employee. Some Plan provisions differ depending on your bargained classification, the Company you work for and other factors. This SPD notes these differences. In the interest of brevity, any time an exception pertaining to a particular Company or Employee group covered by a bargained contract exists, the SPD may refer to the Company or Employee group by an acronym rather than an official Company or Employee group name.

A complete list of Participating Company names and Employee groups covered by collective bargaining agreements is located in "Appendix A" *Participating Companies and Applicable Collective Bargaining Agreements*.

CONTENTS

OVERVIEW

The Plan permits Eligible Employees to choose from a menu of different benefits and to pay for those benefits on a before-tax basis. This type of plan is commonly referred to as a cafeteria plan because you can pick and choose among several different benefits.

Four distinct before-tax benefits are offered under the Plan: the Before-Tax Premium Option, the Health Care Flexible Spending Account, Health Savings Account (HSA) Payroll Contributions and the Dependent Care Flexible Spending Account. Not all Employees are eligible for all benefits. The Plan also permits the Company to make tax-free contributions to a Health Savings Account that an Eligible Employee establishes with the trustee/custodian to whom before-tax Payroll deductions can be contributed. See the applicable sections for information on eligibility and other important provisions.

The Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (Code) and the regulations issued thereunder and will be interpreted to accomplish that objective.

The Plan was amended to comply with the Patient Protection and Affordable Care Act, as amended, and the regulations issued thereunder (the PPACA), and will be interpreted accordingly.

Before-Tax Premium Option

The Before-Tax Premium Option (BTPO) enables Eligible Employees to pay contributions for Company-sponsored health care plans (including fully-insured options) and certain welfare plans on a before-tax basis (Eligible Contributions). For this purpose, Company-sponsored health care plans include the Company's medical, dental, and vision benefit programs. The BTPO also applies to contributions for the Company-sponsored supplemental accidental loss insurance and dependent accidental loss insurance programs. If you are an Eligible Employee and you participate in any of the Company-sponsored health care plans or certain welfare plans, your contributions are automatically deducted on a before-tax basis unless you elect otherwise.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (Health Care FSA) offers Eligible Employees the option to pay, on a before-tax basis, for certain anticipated out-of-pocket health care expenses that a health care plan does not cover. If you elect to participate in the Plan's Health Care FSA, you authorize the Company to reduce your salary by the amount of your election.

Health Savings Account Payroll Contributions

Health Savings Account (HSA) Payroll Contributions give Eligible Employees the opportunity to make before-tax contributions to an HSA established and maintained with the HSA trustee/custodian to whom before-tax Payroll deductions can be contributed. Contributions to an HSA can be used to help pay for certain out-of-pocket health care expenses that a health plan does not cover. If you elect to participate in the HSA Payroll Contributions portion of the Plan, you authorize the Company to reduce your salary by the amount of your election.

To participate in an HSA, you must satisfy certain conditions. You must be enrolled in a medical plan that meets Code Section 223 requirements for a high-deductible health plan. The AT&T Medical Program consumer-driven health plan option is designed to meet these requirements for nonbargained Employees and some Bargained Employees. The Company may limit the HSA trustee/custodians to whom before-tax Payroll deductions can be contributed.

Health Savings Account Company Contribution

An HSA Company Contribution is available to certain Eligible Employees who elect to participate in the Silver or Bronze Option of the AT&T Medical Program and makes before-tax HSA Payroll Contributions in required amounts. Please see the section titled "Health Savings Account Company Contributions" for more information.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account (Dependent Care FSA) is a separate component of the Plan that offers an Eligible Employee the option to pay, on a before-tax basis, for certain anticipated dependent care expenses that you incur so that you and your spouse, if applicable, can work outside the home. If you elect to participate in the Plan's Dependent Care FSA, you authorize the Company to reduce your salary by the amount of your election.

How the Health Care FSA, HSA and Dependent Care FSA Work

When you enroll in a Health Care FSA, HSA or Dependent Care FSA, or any combination of them, you determine the amount of money you want contributed to these reimbursement accounts. Deposits are made on a before-tax basis through Payroll deduction and, when you incur Eligible Expenses, you receive tax-free reimbursements from the account throughout the year. Since you do not pay taxes on your contributions, you actually reduce your taxable pay and increase your take-home pay.

If you have not incurred enough Eligible Expenses by Dec. 31 to claim reimbursement of all of the contributions to your Health Care FSA and/or Dependent Care FSA contribution account(s) for that year, the law requires that you forfeit the money remaining in your account(s). By Contrast, balances in your HSA carry forward from year to year and can continue to grow with interest or earnings; you will **not** forfeit the unused balance in your HSA each year. Also, contributions to the Health Care FSA and HSA cannot be used to cover expenses eligible for reimbursement under the Dependent Care FSA, and vice versa. You should, therefore, carefully plan your contributions.

ELIGIBILITY AND PARTICIPATION

KEY POINTS

- *Only Eligible Employees can participate in this Plan.*
- *If you are an Active Bargained Employee whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union or you are a Nonmanagement Nonunion Employee who is extended Bargained Employee benefits, you are an Eligible Employee only if the Plan or its benefits are described in the collective bargaining agreement.*
- *You become eligible to enroll after you complete your Eligibility Waiting Period. See "Appendix B" Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limits Matrix section for the Eligibility Waiting Period that applies to you.*

This section summarizes the eligibility provisions of the Plan for Eligible Employees. If, after reading this information, you still have questions or wish to confirm eligibility, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Eligible Employees

Only Eligible Employees can elect to participate in this Plan. An Eligible Employee is an Active Employee who satisfies all other eligibility requirements. See "Appendix A" *Participating Companies and Applicable Collective Bargaining Agreements*, for a list of Participating Companies. In addition, if you are an Active Bargained Employee whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union or you are a Nonmanagement Nonunion Employee who is extended Bargained Employee benefits, you are an Eligible Employee only if the Plan is included in the collective bargaining agreement. However, an Eligible Employee does not include any common-law employee who is a leased employee or who is classified by the Participating Company as a contract worker or independent contractor.

IMPORTANT: Employees located in Puerto Rico are not eligible for FSAs.

If you are a Management Employee or Nonmanagement Nonunion Employee that follows the management level of benefits, your coverage effective date is the first of the month after you enroll.

If you are a Bargained Employee or Nonmanagement Nonunion Employee that follows the Bargained Employee level of benefits, you become eligible to enroll after you complete your Eligibility Waiting Period. See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limit Matrix* for the Eligibility Waiting Period that applies to you. An Eligibility Waiting Period is the period after you are employed by a Participating Company that you must wait to enroll in the Plan. Your coverage effective date is also determined by your Eligibility Waiting Period provided in "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limits Matrix*, provided you timely enroll. See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limits Matrix*, for provisions that apply to you. See the "Enrollment and Changes to Your Coverage" section for more information about enrolling.

Former Employees

The law does not allow Former Employees to participate in the Plan, except through COBRA continuation coverage for the Health Care FSA (see the "COBRA Continuation Coverage" section for information on COBRA coverage).

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

- *Your BTPO, Health Care FSA and/or Dependent Care FSA elections will be effective on the first day of the month following your enrollment.*
- *If you are a current Eligible Employee, your BTPO contributions are automatically deducted from your pay on a before-tax basis.*
- *If you are eligible for an HSA, you may elect before-tax HSA Payroll Contributions at any time after you open your HSA with a trustee/custodian with whom the Company has made arrangements. See the "HSA Eligibility" section for more information.*

- *Your BTPO, Health Care FSA and Dependent Care FSA elections cannot be changed during the calendar year unless you meet certain requirements.*
- *If you are not participating in the BTPO or Health Care FSA portions of the Plan when you gain or lose eligibility for Medicaid or CHIP coverage, you can enroll in the Plan's BTPO or Health Care FSA if you do so within 60 days.*

As a newly Eligible Employee, your BTPO, Health Care FSA and/or Dependent Care FSA elections will begin on the first day of the month following your enrollment, provided you are eligible and have completed your Eligibility Waiting Period. See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limits Matrix* section for the Eligible Employee Group, Eligibility to Enroll and the Eligibility Waiting Period that applies to you. Your BTPO contributions will automatically be deducted from your pay on a before-tax basis. If you do not want your BTPO contributions deducted on a before-tax basis you must contact the Eligibility and Enrollment Vendor within 31 days of your date of hire or the date you receive your enrollment kit, whichever is later, and make an election to have your BTPO deductions made on an after-tax basis. As a newly Eligible Employee, your first payroll deductions for these benefits may include two months of contributions, depending on the date you enrolled.

You may make changes to your Plan elections during an annual enrollment period, within 31 days following a Qualified Status Change event (see the "Qualified Status Changes" section and "Appendix C" *Qualified Status Changes Matrix* for more information), or within 60 days of a Special Enrollment Event. If the Qualified Status Change event is your covered dependent's death, the 31-day notice period does not apply.

You will be notified in advance of the timing and duration of the annual enrollment period so that you can make timely elections regarding Plan benefits.

The following chart describes how to enroll and the effective date of your participation:

Enrollment and Effective Dates for Eligible Employees	
If you are ...	**Then ...**
Currently employed	**Before-tax Premium Option (BTPO)**. Your Eligible Contributions are automatically deducted from your pay on a before-tax basis. If you do not want these contributions deducted on a before-tax basis, then you must elect to have them deducted on an after-tax basis each year during annual enrollment. Your annual enrollment election will be effective on the Jan. 1 immediately after it is made. You may not change your BTPO election during the year **unless** you experience a Qualified Status Change event (see the "Qualified Status Changes" section and "Appendix C" *Qualified Status Changes Matrix* for more information). If you experience a Qualified Status Change event and want to change your BTPO election, you must contact the Eligibility and Enrollment Vendor within 31 days of your Qualified Status Change event. If the Qualified Status Change event is your covered dependent's death the 31-day notice period does not apply. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information. A change to your BTPO election as a result of a Qualified Status Change is effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor.

Enrollment and Effective Dates for Eligible Employees	
If you are ...	**Then ...**
Currently employed	**Health Care FSA and/or Dependent Care FSA.** You may enroll in either the Health Care FSA and/or Dependent Care FSA each year during annual enrollment. Your annual enrollment election will be effective on the Jan. 1 immediately after it is made. You may not change your Health Care FSA and/or Dependent Care FSA election during the year **unless** you experience a Qualified Status Change event (see the "Qualified Status Changes" section and "Appendix C" *Qualified Status Changes Matrix* for more information). If you experience a Qualified Status Change event and want to enroll in or change your Health Care FSA and/or Dependent Care FSA election, you must contact the Eligibility and Enrollment Vendor within 31 days of your Qualified Status Change event. If the Qualified Status Change event is your covered dependent's death the 31-day notice period does not apply. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information. A change to your FSA or enrollment as a result of a Qualified Status Change is effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor.
Currently employed	**Health Savings Account (HSA) Payroll Contributions.** To make before-tax HSA Payroll Contributions, you must satisfy certain legal requirements, including that you must be enrolled in a consumer-driven medical plan like the AT&T Medical Program under AT&T Umbrella Benefit Plan No. 3, which is designed to meet the Code requirements for a high-deductible health plan with regard to nonbargained Employees and some Bargained Employees. You may make an election for HSA Payroll Contributions during annual enrollment or at any time during the year by contacting the Eligibility and Enrollment Vendor. Your HSA Payroll Contribution will be effective Jan. 1 if made during annual enrollment or if made at any other time, the month following your election, or as soon as administratively feasible. If you do not already have an open HSA with a trustee/custodian to whom the Company has agreed to make before-tax contributions on your behalf, one will automatically be opened for you. You will be required to take further action with the HSA trustee/custodian before you will have full access to all account features (i.e., distribution features and investment alternatives). You may change your HSA Payroll Contributions at any time. Your election to change your HSA Payroll Contributions is effective the first of the following month or as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor.

Enrollment and Effective Dates for Eligible Employees	
If you are ...	**Then ...**
A new Eligible Employee who wants to make HSA Payroll Contributions, enroll in the Health Care FSA and/or Dependent Care FSA or elect after-tax treatment under the BTPO	**Health Care FSA, Dependent Care FSA and/or BTPO.** You must contact the Eligibility and Enrollment Vendor to enroll within 31 days of your date of hire or the date you receive your enrollment kit, whichever is later. Your BTPO, Health Care FSA and/or Dependent Care FSA elections will begin the first of the month following your enrollment, provided you are eligible and have completed your Eligibility Waiting Period. See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limit Matrix* for a summary of the Eligible Employee Group, Eligibility to Enroll, Eligibility Waiting Period, and Contribution Limits that apply to you. If you do not enroll in the Health Care FSA and/or Dependent Care FSA within 31 days of your date of hire or the date you receive your enrollment kit, you cannot enroll until the next annual enrollment period, unless you have a Qualified Status Change event. If you do not elect after-tax treatment under the BTPO within 31 days of your date of hire, your Eligible Contributions will be deducted from your paycheck on a before-tax basis; you cannot elect after-tax treatment until the next annual enrollment period unless you have a Qualified Status Change event (see the "Qualified Status Changes" section and "Appendix C" *Qualified Status Changes Matrix* for more information). **Health Savings Account (HSA) Payroll Contributions.** To make before-tax HSA Payroll Contributions, you must satisfy certain legal requirements, including that you must be enrolled in a consumer-driven medical plan like the AT&T Medical Program under AT&T Umbrella Benefit Plan No. 3, which is designed to meet the Code requirements for a high-deductible health plan with regard to nonbargained Employees and some Bargained Employees. You may make an election for HSA Payroll Contributions during annual enrollment or at any time during the year by contacting the Eligibility and Enrollment Vendor. Your HSA Payroll Contribution will be effective Jan. 1 if made during annual enrollment or if made at any other time, the month following your election, or as soon as administratively feasible. If you do not already have an open HSA with a trustee/custodian to whom the Company has agreed to make before-tax contributions on your behalf, one will automatically be opened for you. You will be required to take further action with the HSA trustee/custodian before you will have full access to all account features (i.e., distribution features and investment alternatives). You may change your HSA Payroll Contributions at any time. Your election to change your HSA Payroll Contributions is effective the first of the following month or as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor.

Special Enrollment for Employees and Their Dependents Who Lose Eligibility for Medicaid or CHIP Coverage or Gain Eligibility for State Subsidies to Participate in the Plan

An Eligible Employee who is not currently enrolled for coverage under the Plan may enroll in the Plan if either of the following conditions is met (Special Enrollment Event):

- The Eligible Employee requests Plan coverage within 60 days after the termination of either the Employee's or their dependents' coverage under Medicaid or Children's Health Insurance Program (CHIP) because they are no longer eligible for the coverage, or
- The Eligible Employee or their dependents become eligible for Medicaid or CHIP premium assistance subsidies and the Employee requests coverage within 60 days after the eligibility is determined.

Changing Your HSA Payroll Contribution Election

You may enroll or change your before-tax HSA Payroll Contribution election at any time. To make a change to your HSA Payroll Contribution election, you must contact the Eligibility and Enrollment Vendor. Your election to change your before-tax HSA Payroll Contribution is effective the first of the following month or as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor.

Changing Your BTPO, Health Care FSA and/or Dependent Care FSA Elections

Generally, you may not enroll, change, or drop your BTPO, Health Care FSA or Dependent Care FSA election(s) during a calendar year. However, election changes during the calendar year are permitted if you experience a Special Enrollment Event (for BTPO and Health Care FSA only) or a Qualified Status Change event and the election change is on account of and consistent with the Qualified Status Change event. The Plan Administrator has the discretion to determine whether an election change is on account of and consistent with the Qualified Status Change event.

Qualified Status Changes

The following events are examples of Qualified Status Changes that **may** allow you to enroll, change or drop your BTPO, Health Care FSA and/or Dependent Care FSA election(s):

- Marriage, divorce or legal separation of a Participant
- Birth or adoption of a child
- Death of a spouse, child or other dependent
- Gain or loss of a dependent
- Commencement or termination of employment of the Participant or spouse
- Switching from part-time to full-time employment status or vice versa by the Participant or spouse
- Taking or returning from an unpaid leave of absence of 30 days or more by the Participant or spouse

For more information regarding specific Qualified Status Changes, see "Appendix C" *Qualified Status Changes Matrix*.

You must contact the Eligibility and Enrollment Vendor within 31 days of any Qualified Status Change event if you want to change your BTPO, Health Care FSA or Dependent Care FSA election(s). If the Qualified Status Change event is the death of your covered dependent, the 31-day notice period does not apply. You will not be allowed to change these election(s) if you notify the Eligibility and Enrollment Vendor after this time period. The change in these election(s) will be effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor of your Qualified Status Change. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Rehire and Return to Work Situations

If your employment terminates or you go on a leave of absence and you subsequently return to work within the same calendar year, you may make new elections, provided that you return to the Payroll more than 30 days after you terminated employment or went on a leave of absence. If you return to the Payroll within 30 days during the same calendar year, your prior elections will be reinstated.

Leave of Absence

Health Care FSA. If you go on a paid leave of absence, your participation in the Plan will continue as if you remained actively employed. If you go on an unpaid leave of absence, your before-tax contributions through Payroll deduction will cease. You will be given the opportunity to continue making contributions through the end of the calendar year to your Health Care FSA, but on an after-tax basis through a direct-bill process.

If you elect to make after-tax contributions to your Health Care FSA through the direct bill process, current guidelines provide that billing notices are sent on the 15th of each month for the following month. Your full payment is due by the first day of each month, with a 60-day grace period. If full payment is not received before the end of your grace period, your right to make after-tax contributions while on a leave of absence will end.

Dependent Care FSA. If you go on a paid leave of absence, your Plan participation will continue as if you remained actively employed. If you go on an unpaid leave of absence, your participation and contributions through Payroll deduction will cease.

Health Savings Account. If you go on a paid leave of absence your contributions to your HSA will continue as if you remain actively employed. If you go on an unpaid leave of absence, your contributions through Payroll deduction will cease. You may continue your HSA contributions by making direct contributions to your HSA bank, however it is your responsibility to know and adhere to the maximum contribution limits per Internal Revenue Service (IRS) regulations, reflecting periods of coverage under a high-deductible health plan.

Disability

If you are receiving short-term disability benefits under a Company-sponsored disability benefit plan, your HSA, Health Care FSA and Dependent Care FSA deductions will continue to be deducted from your benefits check. Since your disability does not affect your eligibility to participate in the Plan, your disability is not a Qualified Status Change for purposes of the Health Care FSA, and you may not elect to change your Health Care FSA contributions upon your disability. However, your disability *is* a Qualified Status Change for purposes of the Dependent Care FSA, and you may elect to change your Dependent Care FSA contributions upon your disability.

Modifications Required by the Plan Administrator

The Plan Administrator may reduce your contributions during the Plan Year if you are a key Employee or highly compensated individual (as defined by the Code). Such a reduction may be necessary to prevent the Plan from becoming discriminatory within the meaning of federal income tax law. If the Plan Administrator makes a mistake

(i) as to your eligibility or participation,

(ii) the allocations made to your account(s), or

(iii) the amount of benefits to be paid to you or another person,

then the Plan Administrator may take certain action. To the extent that it deems the action 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 the account or distributions to which you or such other person is properly entitled under the Plan. Such action by the Plan Administrator may include reporting the information as taxable income on your Form W-2 or withholding of any amounts due from your compensation.

WHEN COVERAGE ENDS

If your employment ends, your Plan participation ends on the last day of the month in which your employment ends. However, you may elect to continue participation in the Health Care FSA by making contributions as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA), which would allow you to avoid a forfeiture of the funds remaining in your account. See the "COBRA Continuation Coverage" section for additional information about COBRA.

Coverage will also end on the earlier of when:

1. The date the Plan terminates
2. The date your Participating Company stops participating in the Plan
3. The date an applicable collective bargaining agreement stops providing for Plan coverage or benefits
4. The date you go on an unpaid leave of absence, provided that you may be eligible to extend your participation in the Health Care FSA option through after-tax contributions
5. The date you no longer meet the eligibility or participation requirements outlined above, provided that you may be eligible to extend your participation in the Health Care FSA option through COBRA continuation coverage.

You have until March 31 of the calendar year following the year during which you were a Participant in the Plan to submit Claims to your Health Care FSA and Dependent Care FSA for reimbursement of expenses incurred while you were a Participant.

CONTRIBUTIONS

If you decide to make before-tax HSA Payroll Contributions or to establish a Health Care FSA and/or Dependent Care FSA under the Plan, contributions are deducted from your paycheck each pay period before taxes are taken out. Also, Eligible Contributions such as your Company-sponsored health care plan contributions and/or contributions for supplemental accidental loss

insurance and dependent accidental loss insurance programs sponsored by AT&T, if any, will be deducted on a before-tax basis under the BTPO unless you elect otherwise.

If you are paying contributions for your Company-sponsored health care program on a before-tax basis and you elect to change your participation to another Company-sponsored health care program that has a different monthly contribution, the amount deducted from your paycheck on a before-tax basis **will not change** for the rest of the calendar year unless you experience a Qualified Status Change event**.** If you switch to another Company-sponsored health care program within 31 days of a Qualified Status Change event (see "Appendix C" *Qualified Status Changes Matrix* and the "Qualified Status Changes" section for further information), then the amount of your before-tax contribution will change accordingly.

For example, if you elect to participate in a Fully-Insured Managed Care Option under the Company-sponsored medical program, you may be required to pay contributions for that coverage. If during the calendar year, you elect a different option (other than a Fully-Insured Managed Care Option) with a higher or lower required Employee contribution, but you do **not** experience a Qualified Status Change, the amount of your original contribution will still be deducted from your pay on a before-tax basis. If the contribution for the newly elected Company-sponsored health care program is more, the excess will be taken from your paycheck on an after-tax basis; if less, the higher amount will continue to be taken from your paycheck on a before-tax basis.

The Company's HSA Contribution, your HSA Payroll Contributions and your Health Care FSA and/or Dependent Care FSA contributions are not subject to federal income taxes, state income taxes (in most states) or Social Security taxes. Because you reduce your income for Social Security tax purposes, your contributions to Social Security will be reduced. However, since your final Social Security benefits are based on your entire earnings history, a reduction in your earnings for before-tax contributions under this Plan should have little effect on your final Social Security benefit. Participation in the Plan will not reduce your compensation for purposes of determining any other Company-sponsored benefits. Other Company-sponsored benefits (e.g., life insurance, pension and 401(k) savings) will continue to be based on your salary before your HSA Payroll Contributions or your Dependent Care FSA and/or Health Care FSA contributions are deducted from your paycheck. HSA Payroll Contributions and Dependent Care FSA and Health Care FSA contributions will not be taken from special payments such as Team Award payments.

The Health Care FSA has a minimum contribution of $100 and a maximum contribution that varies by Eligible Employee group and Participating Company. See "Appendix A" *Participating Companies and Applicable Collective Bargaining Agreements* for an explanation of Eligible Employee Group terms. See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limit Matrix* for a listing of your Eligible Employee Group, Eligibility Waiting Period, and minimum and maximum Health Care FSA contribution amounts.

HOW THE HSA AND FSA WORK

KEY POINTS

- *Your HSA, Health Care FSA and/or Dependent Care FSA are tax-effective ways to be reimbursed for certain types of Eligible Expenses.*
- *Federal tax law places some restrictions on the use of HSAs, Health Care FSAs and Dependent Care FSAs because of their tax advantages.*
- *The tax benefits of Plan participation do NOT extend to coverage for a Domestic Partner (DP) or Legally Recognized Partner (LRP) and their children unless the DP, LRP, or their children are dependents within the meaning of the Code.*

You may use your HSA, Health Care FSA and/or Dependent Care FSA as a tax-effective way to be reimbursed for certain types of Eligible Expenses. When you elect to make HSA Payroll Contributions or enroll in a Health Care FSA or Dependent Care FSA, you agree to have your salary reduced instead of having a corresponding amount of your regular pay taxed. The amount by which you elect to reduce your salary and contribute to your HSA, Health Care FSA and/or Dependent Care FSA is taken from each of your paychecks on a before-tax basis on a pro-rata basis throughout the calendar year.

When you have Eligible Expenses, you first pay the bills as you normally do. You then use the money in your HSA, Health Care FSA and/or Dependent Care FSA like cash, to reimburse yourself or to pay the service provider for Eligible Expenses. You do not pay taxes on the money set aside in your HSA, Health Care FSA and Dependent Care FSA. The tax advantage of the account is that you pay less federal, state (in most states), and local income tax (if applicable) and Social Security taxes, which increases the amount of your take-home pay.

For example, assume you earn $30,000 per year, you elect to contribute $2,500 to your Health Care FSA and $2,000 to the Dependent Care FSA and you have Eligible Expenses for reimbursement.

Here's an example of how contributions to your FSA accounts can reduce the amount of taxes you pay.

	With FSA (Before-Tax)	Without FSA (After-Tax)
Annual Base Salary	$30,000	$30,000
Health Care FSA contributions	- 2,500	
Dependent Care FSA contributions	- 2,000	- 0
Taxable salary	$25,500	$30,000
Federal income tax (estimated*)	- 3,825	- 4,500
Social Security (FICA) tax (7.65%)	- 1,951	- 2,295
After-tax expenses	- 0	- 4,500
Take-home salary	$19,724	$18,705
Tax Savings	**$1,019**	

In this example, by contributing on a before-tax basis to a Health Care FSA and Dependent Care FSA, you would increase your take-home pay by $1,019. This example assumes the maximum Health Care FSA contribution is $2,500.

**Based on 15 percent tax rate.*

Limitations on Health Care FSA and Dependent Care FSA

Federal law places some restrictions on the use of Health Care FSAs and Dependent Care FSAs because of their tax-free nature. **Unless otherwise noted, these limitations DO NOT apply to an HSA.** Before you decide to have money deposited in a Health Care FSA or a Dependent Care FSA, you should understand the rules that govern their use.

- Contributions made to an HSA or a Health Care FSA cannot be used to cover expenses eligible for reimbursement under the Dependent Care FSA and vice versa.
- To be eligible for reimbursement from a Health Care FSA or a Dependent Care FSA, the eligible services need to be provided, or the Eligible Expense for products needs to be incurred, between Jan. 1 and Dec. 31 of the year during which you contributed to the Health Care FSA and/or Dependent Care FSA, and while you were an active Participant in the Health Care FSA and/or Dependent Care FSA.
- You have a three-month grace period after the calendar year ends in which to submit all requests for FSA reimbursement of Eligible Expenses incurred during that year. This means you must submit a Claim for reimbursement to the Claims Administrator for receipt by March 31 of the calendar immediately after the year in which you incurred the Eligible Expense. If you do not file a timely Claim for reimbursement, you will forfeit any amounts remaining in your Health Care FSA or your Dependent Care FSA.

> **IMPORTANT**: Federal law requires that you forfeit any funds remaining in your Health Care FSA and/or Dependent Care FSA after all Eligible Expenses for the year have been reimbursed. So, you will want to carefully choose how much you contribute to your Health Care FSA and/or Dependent Care FSA for the year.

- The amount available for reimbursement from your Health Care FSA at any time during the calendar year is the total amount you elected to contribute for that year, less any reimbursements you already received for that year.
- The amount available for reimbursement from your Dependent Care FSA at any time during the calendar year is limited to the total amount actually contributed to your Dependent Care FSA at the time of your reimbursement request, less any reimbursements you already received for that year.
- You do not receive interest on your Health Care FSA and/or Dependent Care FSA accounts.
- The tax benefits of participation in the Plan do **not** extend to Eligible Expenses incurred by your Domestic Partner (DP) or Legally Recognized Partner (LRP) and their children unless these individuals also qualify as your dependent within the meaning of federal tax laws. For example, unless your DP or LRP qualifies as your dependent for federal tax purposes, you cannot:
  - Pay for Company-sponsored medical program coverage for your DP or LRP and their children on a before-tax basis.
  - Receive reimbursement from a Health Care FSA for otherwise Eligible Expenses incurred on behalf of your DP/LRP or their children.
  - Receive reimbursement from your Dependent Care FSA for otherwise Eligible Expenses incurred on behalf of your DP/LRP or their children.

HEALTH CARE FSA

KEY POINTS

- *Before-tax contributions to a Health Care FSA can be used to reimburse eligible out-of-pocket health care expenses incurred on your behalf or on behalf of your Eligible Dependents during the year.*
- *If you make HSA Payroll Contributions, the types of Eligible Expenses that can be reimbursed from your Health Care FSA generally will be limited to dental, vision, and preventive care expenses.*
- *If you don't make before-tax HSA Payroll Contributions under this Plan, expenses incurred for medical care within the meaning of Section 213(d) of the Code may be reimbursed from your Health Care FSA.*
- *The minimum and maximum Health Care FSA contributions vary by Eligible Employee group.*

You may use your Health Care FSA to reimburse yourself for eligible health care expenses incurred on your or your Eligible Dependent's behalf that are not reimbursed by any other health care plan. If you participate in the AT&T Health Reimbursement Account Program or any other company-sponsored health reimbursement account plan or program, reimbursement will first be made from your Health Care FSA.

The Plan offers the opportunity to make before-tax contributions to a Health Care FSA, and these contributions are used to reimburse eligible out-of-pocket health care expenses.

The types of Eligible Expenses that can be reimbursed from your Health Care FSA will be restricted to dental, vision and preventive care expenses if you make HSA Payroll Contributions or if you designate your Health Care FSA as limited. You can designate your Health Care FSA as limited by notifying the Eligibility and Enrollment Vendor when you elect your Health Care FSA.

<table>
<tr><th colspan="2">If you are ...</th><th>Then ...</th></tr>
<tr><td colspan="2">An Eligible Employee who does not participate in a high-deductible health plan sponsored by AT&T.</td><td>You may elect to contribute to a Health Care FSA. Any Eligible Expense is reimbursable from your Health Care FSA.</td></tr>
<tr><th colspan="2">If you are...and</th><th>then...</th></tr>
<tr><td rowspan="3">An Eligible Employee who participates in a high-deductible health plan sponsored by AT&T.</td><td>• You are making before-tax HSA Payroll Contributions; or
• You are making contributions to an HSA (or intend to make contributions to an HSA) and you designated your Health Care FSA as “limited” by notifying the Eligibility and Enrollment Vendor at the time you elect your Health Care FSA.</td><td>You may contribute to a Health Care FSA, but your reimbursements will be limited to eligible dental, vision and/or preventive care expenses ONLY, i.e., your Health Care FSA will be designated as a Limited Health Care FSA.</td></tr>
<tr><td>You are not contributing to an HSA.</td><td>You may contribute to a Health Care FSA. Any Eligible Expense is reimbursable from your Health Care FSA, i.e., your Health Care FSA will be designated as a Full Health Care FSA.</td></tr>
<tr><td>You contribute to an HSA but are not making HSA Payroll Contributions, and you did not call the Eligibility and Enrollment Vendor to designate your HSA as “limited.”</td><td>You may contribute to a Health Care FSA. Any Eligible Expense is reimbursable from your Health Care FSA, however, you may not be eligible to make before-tax contributions to your HSA.</td></tr>
</table>

If you elect to contribute to a Health Care FSA during annual enrollment or when you are first eligible to participate in the Plan, and it is a Full Health Care FSA because you did not also elect HSA Payroll Contributions, you will **not** be allowed to make HSA Payroll Contributions. However, you may change the character of your Health Care FSA from Full to Limited at any time during the calendar year (without experiencing a Qualified Status Change event). That change will be effective on the first day of the month following a reasonable period of time after you notify the Eligibility and Enrollment Vendor. If you have a Limited Health Care FSA, you may make HSA Payroll Contributions effective the same date that your Full Health Care FSA is converted to a Limited Health Care FSA. Upon conversion, all amounts in your Health Care FSA, regardless of when contributed, are limited, and you will not be allowed to receive reimbursement for medical and prescription drug claims incurred after the conversion date.

Health Care FSA Contribution Limits

The Health Care FSA has a minimum contribution of $100 and a maximum contribution that varies by Eligible Employee group and Participating Company. See "Appendix A" *Participating Companies and Applicable Collective Bargaining Agreements* for an explanation of Eligible Employee Group terms. See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limit Matrix* for a listing of your Eligible Employee Group, Eligibility Waiting Period, and minimum and maximum Health Care FSA contribution amounts.

Your Health Care FSA

If you elect to contribute to a Health Care FSA, an account will be established in your name to record the before-tax contributions you make and the reimbursements you receive. Your Health Care FSA is a bookkeeping account. The account is not funded. All reimbursements from the Health Care FSA account are paid from the Company's general assets.

Eligible Dependents

Eligible Expenses incurred on your behalf or on behalf of your Eligible Dependents may be reimbursed from your Health Care FSA. For this purpose, your *Eligible Dependents* are:

- Your *spouse* as defined in the Code;
- 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 19 at the end of the year or is a full-time student younger than 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 who you have legally adopted or that 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 over 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 Domestic Partner (DP) or Legally Recognized Partner (LRP) and their dependent(s) only if your DP or LRP and their dependent(s) are a qualifying child or a qualifying relative for federal income tax purposes.

Eligible Expenses

Eligible Expenses reimbursable from your Health Care FSA must have been incurred during the calendar year and while you are an active Participant in the Plan. An expense is incurred when the service that causes 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. In the event you are eligible to increase your Health Care FSA amount in the middle of a Plan Year, you may not apply the increased amount to reimburse expenses that you incur before the effective time of your increased Health Care FSA amount. If you incur an otherwise Eligible Expense while you are on an unpaid leave of absence, it is not reimbursable from your Health Care FSA since you are not an active Participant in the Plan at that time. However, if you elected to continue to maintain your Health Care FSA participation through COBRA, claims for Eligible Expenses incurred during your COBRA period are reimbursable.

Expenses that have been reimbursed by another plan or insurance may not be reimbursed. If you have an HRA, the Health Care FSA will reimburse Eligible Expenses first. Contributions or premiums for coverage are not reimbursable from your Health Care FSA.

Eligible Expenses that may be reimbursed from your Health Care FSA depend on whether you are contributing to a Full Health Care FSA or a Limited Health Care FSA. (See the "Limitations Applicable to Health Care FSAs and HSA Payroll Contribution Participants" section for more information on a Full Health Care FSA and Limited Health Care FSA.)

Eligible Expenses that may be reimbursed from your *Limited* Health Care FSA are expenses incurred for:

- Services or treatments for dental care;
- Services or treatments for vision care; or
- Services or treatment for preventive care. Preventive care is generally defined to include any service to the extent necessary (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., smoking cessation programs). Preventive care does not include services or treatments that treat an existing condition.

Eligible Expenses that may be reimbursed from your *Full* Health Care FSA are expenses incurred for medical care within the meaning of Section 213(d) of the Code. A partial list of Eligible Expenses reimbursable from your Full Health Care FSA includes the following:

- 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 purchased over-the-counter without a prescription is eligible for reimbursement.
- 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 **http://www.irs.gov/pub/irs-pdf/p502.pdf.** However, you should use this IRS publication with caution because it was prepared for describing deductible medical expenses for federal income tax purposes, not to determine which expenses are reimbursable from a Health Care FSA. Not all expenses deductible for federal income tax purposes are reimbursable from a Health Care FSA.

Ineligible Expenses

A partial list of health care expenses **not** eligible for reimbursement from your Full Health Care FSA includes the following:

- Any expenses paid by any health care plan or reimbursed by insurance
- Professional services and medical treatments
- 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
- 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 Health Care FSA 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
- Over-the-counter (OTC) medicines purchased without a prescription, except insulin
- 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 such as through your spouse's employer or an individual carrier
- 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 of student
- Expenses of divorce, where 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 a 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 Health Care FSA, 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 **http://www.irs.gov/pub/irs-pdf/p502.pdf.**

How to File Health Care FSA Claims for Reimbursement

Many of your Health Care FSA Claims for reimbursement are processed automatically and others require that you submit a written, mobile application or online Claim for reimbursement.

Automatic Processing of Your Health Care FSA Claims

If you are enrolled in a Company-sponsored medical program managed by a Participating Administrator and you have a Full Health Care FSA, your medical program out-of-pocket health care expenses, such as copayments, coinsurance and deductibles, will automatically be sent to your Health Care FSA for processing. The automatic Claims process is convenient and saves time by reducing the need for you to prepare and file Health Care FSA reimbursement Claims with the Claims Administrator and allows the Claims Administrator to process the Claims from Participating Administrators without the need for additional information. The Participating Administrators will electronically submit your Claims directly to the Plan's Claims Administrator for processing.

If you incur eligible out-of-pocket health care expenses through a *nonparticipating administrator*, you are required to prepare and file Claims for reimbursement.

Participating Administrators

Participating Administrators that will automatically submit Health Care FSA Claims to the Claims Administrator are:

- UnitedHealthcare (medical, and/or AT&T CarePlus – A Supplemental Benefit Program)
- Blue Cross and Blue Shield of Illinois (medical)
- CVS Caremark (prescription drug)
- Beacon Health (mental health/chemical dependency; mental health/substance abuse)
- CIGNA Dental (dental)
- EyeMed Vision Care (vision)

Automatic Claims Reimbursement

The Claims Administrator provides you with the automatic reimbursement of Health Care reimbursement claims submitted by a Participating Administrator. You can elect not to participate in automatic Claims reimbursement at any time by logging onto the Claims Administrator's website and choosing manual Claims reimbursement, or by calling the Healthcare FSA Claims Administrator (see the "Contact Information" section for the Claims Administrator's contact information). This action will not affect your continued participation in the Health Care FSA for the remainder of the calendar year - only how and when your Claims will be reimbursed.

Manual Claims Reimbursement

Manual Claims reimbursement provides you with the opportunity to select which eligible Claims will be reimbursed from your FSA and when. Payment will be issued within two to three business days of your approval of a Claim approved by the Claims Administrator.

Filing Claims for Processing of Your Health Care FSA Claims

You must submit a Claim if you have a dependent not participating in an AT&T health benefit program, or you incur eligible out-of-pocket medical care expenses at any time during the year through a nonparticipating health care provider. Your Claim, along with your paid receipt and explanation of benefits or other documentation showing amounts paid by the AT&T medical, dental or vision program or other insurance, is needed for you to receive reimbursement from your Health Care FSA.

Follow these steps to file a written Health Care FSA Claim:

1. Pay the expense by its due date. You may not receive payment from your Health Care FSA until after you first pay the expense. Do not wait to pay the expense.
2. Enter your claim online (or through the mobile application), or by calling to request a paper claim form (see the Claims Administrator for the Plan table in the "Contact Information" section).
3. Provide a receipt from the health care provider. For expenses partially covered by your health plan, provide a copy of your health plan's explanation of benefits (EOB). For expenses related to your purchase of a prescription drug, include the drug's name on your Claim for prescription reimbursement.
4. Complete and submit your Claim and receipt(s) online or to the address on the bottom of the form or print a cover sheet, sign-it and then fax it to the number provided on the form (see the *Claims Administrator for the Plan* table in the "Contact Information" section).
5. Be sure to keep a copy of the receipt and, if applicable, your form in case you need to provide more information about your Claim.
6. The Claims Administrator must receive your claim and receipts/complete documentation by March 31 of the year after the year in which you incurred the Eligible Expense and contributed to your Health Care FSA.

Reimbursement From Your Health Care FSA

Available Reimbursement Amounts

The amount available for reimbursement from your Health Care FSA at any time throughout the Plan Year is the total amount elected for the Plan Year, *less* any reimbursements you already received for that Plan Year. If you are eligible to increase your Health Care FSA amount in the middle of the Plan Year, you may not apply the increased amount to reimburse expenses that you incur before the effective time of your increased Health Care FSA amount.

You **cannot** carry over a balance in your Health Care FSA from one Plan Year to the next. If you have not incurred enough eligible expenses by Dec. 31 to claim all deposits made to your Health Care FSA, the law requires you to forfeit any remaining money.

All Claims for expenses incurred while a Participant during the prior Plan Year must be received by the Claims Administrator on or before March 31 of the next year.

Health Care FSA forfeitures and uncollected Health Care FSA benefits will be used to offset losses experienced by the Plan Administrator or the Company resulting from reimbursements to Participants in the Plan's Health Care FSA that exceed Health Care FSA salary reductions and then to reduce Plan administration costs.

Reimbursement by Check

After your Claim for reimbursement is processed and approved, the Claims Administrator will send you a reimbursement check for Eligible Expenses incurred up to the amount you elected to contribute to your Health Care FSA, reduced by any reimbursements you previously received. Your reimbursement check is generally mailed within *two to three business days of Claim* approval. Your reimbursement check will be attached to an Explanation of Benefits (EOB) detailing the Claim payment.

> Note: *Issued check payments are valid for six months (180 days) from the date on the check. If not cashed within six months of issuance, the check will expire and will be stale voided. To have a check payment reissued, contact the AT&T Benefits Center.*

Reimbursement by Electronic Funds Transfer

Alternatively, you can have your reimbursement amount electronically deposited directly into your checking or savings account. With electronic funds transfer (EFT), you can begin receiving Claim payments within a few business days after your Claim is approved. If you provide the Claims Administrator with your email address, you will receive updates on reimbursement activity and account activity statements. With email communications, you can receive a complete EOB statement (total expense paid, partial payment or full denial) whenever a Claim is processed.

To participate in EFT, you may elect direct deposit online on the Claims Administrator's website, by mobile application or by calling the Claims Administrator. The "Contact Information" section includes the phone number and address for the Claims Administrator.

Pay Your Provider

If you enter your Claim on-line or have auto-claims submission with manual pay, and include your provider information, you can have the Claims Administrator pay the amount of the Eligible Expense directly to your provider. If you do not have a balance in your FSA account to pay the full amount of the Eligible Expense submitted then the payment will be made to the Participant. This feature is not available if you are participating in auto-claim submission with auto reimbursement, mobile application or filing a paper Claim.

HSA PAYROLL CONTRIBUTIONS

KEY POINTS

- *If you elect to make before-tax HSA Payroll Contributions, you must select an HSA custodian/trustee who has entered into an arrangement to accept HSA Payroll Contributions from the Company and an HSA will be opened for you with that custodian/trustee as part of enrollment.*
- *To participate in the HSA, you must meet certain requirements.*

- *You will not be allowed to make HSA Payroll Contributions if you participate in a Full Health Care FSA – one that reimburses all of your eligible medical expenses. You may, however, be eligible to make HSA Payroll Contributions and participate in a Limited Health Care FSA – one that reimburses only your eligible dental, vision, and preventive care expenses.*
- *HSA Payroll Contributions stop when your employment with the Company ends or you go on an unpaid leave of absence, but you do not forfeit the balance in your account.*
- *The maximum contribution limits set by the IRS include both employer and employee HSA contributions.*

IMPORTANT: Employees in Hawaii and Puerto Rico may not make before-tax Payroll Contributions to an HSA through payroll deduction.

Before-tax HSA Payroll Contributions under this Plan can be made only to an HSA custodian(s) or trustee(s) with whom the Company has entered into an arrangement to accept before-tax HSA Payroll Contributions.

HSA Eligibility

To participate in an HSA, you must satisfy certain requirements, as follows:

- You must be enrolled in a consumer-driven health plan like the consumer-driven option under the AT&T Medical Program, which is designed to meet Code requirements for a high-deductible health plan with regard to Management Employees and some Bargained Employees.
- You cannot be enrolled in any part of Medicare.
- You cannot be covered by another medical plan that does not qualify as a high-deductible health plan or have other medical coverage, including coverage under a Full Health Care FSA or Health Reimbursement Account (HRA).
- You cannot be claimed as a dependent on someone else's tax return. (For this purpose, a spouse is not considered a dependent).

Your HSA

Before you decide to have money deposited into an HSA, you should understand the rules governing its use.

- You may increase, decrease or stop your HSA Payroll Contributions at any time for any reason.
- Your maximum HSA contribution is limited to the amount authorized by the Code. The maximum contribution limits set by the IRS include both employer and employee contributions. The amount of any HSA Company Contribution that you receive will automatically reduce your total HSA Payroll Contributions to the extent necessary so that your combined HSA Company Contribution and HSA Payroll Contributions do not exceed the lawful maximum HSA contribution amount.

- Catch-up HSA Payroll Contributions are not permissible until the first of the month following your 55th birthday and are limited to a monthly amount equal to 1/12 of the maximum annual catch-up amount. You may, however, make catch-up contributions to your HSA beginning in the calendar year that you turn 55 by making a deposit directly with your HSA provider.
- You may make an HSA contribution (or HSA catch-up contribution for any calendar year in which you become 55 or older) by making a deposit directly with your HSA provider, up to the maximum lawful amount after reduction for any HSA Company Contribution. In this case, the monthly maximum limitation does not apply if you are eligible to make an HSA contribution on Dec. 1, but you must remain HSA eligible through Dec. 31 of the following calendar year to avoid adverse tax consequences.
- You can receive reimbursement of eligible medical care expenses from your HSA at any time in accordance with the rules established by your HSA custodian or trustee.
- Eligible health care expenses must be incurred after your HSA is created for you to be reimbursed from your HSA.
- The maximum reimbursement from your HSA at any point in time is limited to the amount in your HSA at the time that you seek reimbursement.
- You do not forfeit amounts contributed to an HSA, even if an amount is not reimbursed by the end of the year.
- Your HSA Payroll Contributions stop when your employment with the Company ends.
- Your HSA belongs to you, and the funds in your HSA are available to you even after your employment with the Company ends.

HEALTH SAVINGS ACCOUNT COMPANY CONTRIBUTIONS

KEY POINTS

- *An HSA Company Contribution is available to certain Eligible Employees who elect to participate in the Bronze or Silver Option of the AT&T Medical Program.*
- *Eligible Employees must make HSA Payroll Contributions in specified amounts to an HSA that they establish with a trustee/custodian to whom before-tax Payroll deductions can be contributed.*

An HSA Company Contribution is available to certain Eligible Employees who elect to participate in the Bronze or Silver Option of the AT&T Medical Program. If an Eligible Employee, who is not a Bargained Employee (excluding Mobility – Virgin Islands – CWA Bargained Employees), elects to make before-tax HSA Payroll Contributions (in the amounts shown in the table below) to their HSA established with a trustee/custodian (to whom before-tax Payroll deductions can be contributed), the Company will make a quarterly HSA Company Contribution of the amount shown in the table below. The HSA Company Contribution is a quarterly lump sum amount made to your qualifying HSA provided you contribute the minimum required amount to your HSA in the quarter prior to the payment date and you are an Active Employee as of the quarterly payment date of the Company contribution.

Medical Option & Coverage Level	Minimum Quarterly HSA Payroll Contribution to Your HSA	Quarterly HSA Company Contribution
Bronze - Individual	$250 during the quarter or $1,000 year to date	$250
Bronze - Individual + Spouse/LRP, Individual + Child(ren), Family	$500 during the quarter or $2,000 year to date	$500
Silver - Individual	$125 during the quarter or $500 year to date	$125
Silver - Individual + Spouse/LRP, Individual + Child(ren), Family	$250 during the quarter or $1,000 year to date	$250

Important Notes:

- If you arrange for payroll deductions outside of the annual enrollment period, processing requirements will impact the timing of your payroll deductions and potentially your eligibility for the HSA Company Contribution for the quarter in which you begin HSA contributions
  - Your HSA Company Contribution will only be made for quarters in which you have contributed the required amounts through payroll deduction.
  - Once you have met the minimum year-to-date amount you will receive an HSA Company Contribution in future quarters during the year.
  - If you do not meet the minimum HSA contribution for a specific quarter but then achieve the year to date requirement later in the year, you will NOT receive the HSA Company Contribution for prior quarters.
- Changes to medical coverage or HSA election amounts during the year may alter your eligibility for HSA Company Contribution amounts.
- Changes in your employment status, such as transfers to a status other than management (or non-management that does not follow management provisions) before the end of the quarter may impact your eligibility for the HSA Company Contribution.

To receive each HSA Company Contribution, you must elect the Bronze or Silver Option in the AT&T Medical Program, and your election must be in effect on the last day of the quarter prior to the quarterly payment date of the HSA Company Contribution. Also, you must have established your HSA with an HSA custodian/trustee with whom the Company has entered into an arrangement to accept an Eligible Employee's before-tax HSA Payroll Contributions, and you must maintain your HSA Payroll Contribution, at the qualifying amount, until the date of each quarterly HSA Company Contribution.

HSA Company Contributions, under this Plan, will be made only to an HSA custodian(s) or trustee(s) with whom the Company has entered an arrangement to accept an Eligible Employee's before-tax HSA Payroll Contributions.

The amount of any HSA Company Contribution that you receive will automatically reduce maximum allowed HSA Payroll Contributions to the extent necessary so that your combined HSA Company Contribution and HSA Payroll Contributions do not exceed the lawful maximum HSA contribution limit.

HSA IS NOT A COMPANY SPONSORED EMPLOYEE BENEFIT PLAN

Neither the ability to make before-tax HSA Payroll Contributions, the HSA Company Contribution, nor the Company's payment of HSA fees or expenses, if any, causes your HSA to be a Company-sponsored employee benefit plan. Your HSA is an individual trust or custodial account that you open with an HSA trustee or custodian to be used primarily for reimbursement of eligible medical expenses. Consequently, the HSA trustee or custodian will establish and maintain your HSA. The Company has no authority or control over the funds deposited in your HSA. The Company's role is limited to allowing you to make before-tax HSA Payroll Contributions and forwarding those funds, along with any HSA Company Contribution, to the HSA custodian or trustee that is authorized to accept before-tax HSA Payroll Contributions from the Company.

Many financial institutions offer HSAs. You may wish to check with your financial institution concerning the availability and terms of an HSA. To facilitate Employee participation in an HSA, the Company will permit payroll deductions with respect to an HSA that you create at Fidelity Investments.

IMPORTANT: The HSA offered by Fidelity Investments is not an arrangement established or maintained by the Company. Rather, an HSA that you open with Fidelity Investments is an arrangement between you and Fidelity Investments that is established and maintained by Fidelity Investments, the HSA trustee. It is the Company's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

Limitations Applicable to Health Care FSAs and HSA Payroll Contribution Participants

You will not be allowed to make HSA Payroll Contributions if you or your spouse participates in a Full Health Care FSA – one that reimburses all eligible medical expenses. You may, however, be eligible to make HSA Payroll Contributions and participate in a Limited Health Care FSA – one that reimburses only your eligible dental, vision and preventive care expenses. For example, out-of-pocket expenses for contact lenses, eyeglasses and orthodontia would be considered qualified expenses for reimbursement from your Limited Health Care FSA. Your eligible medical expenses could be reimbursed through your HSA. This would include, for example, all medical expenses up to your deductible, coinsurance for office visits and copayments for prescription drugs.

If you do not elect to make HSA Payroll Contributions, but you plan to do so later during the year or you have set up or plan to set up an HSA outside of your HSA Payroll Contributions, you must contact the Eligibility and Enrollment Vendor at the time you make your Health Care FSA election and designate your Health Care FSA as limited.

If you elect to make HSA Payroll Contributions and you elect to contribute to a Limited Health Care FSA, and you later drop the HSA, your withdrawals from the Health Care FSA will continue to be limited through the remainder of the calendar year.

Some employers' health care FSA plans allow participants to receive reimbursement of Eligible Expenses for services provided during the calendar year or within the first two and one-half months of the following calendar year. If you contributed to one of these health care FSA plans, you will not be permitted to make HSA Payroll Contributions until April 1 after the lapse of the two and one-half month period, even if your health care FSA plan has no remaining funds. The

AT&T Flexible Spending Account Plan does not allow health care FSA reimbursements for services received and paid after the end of the calendar year.

DEPENDENT CARE FSA

KEY POINTS

- *The Dependent Care FSA is designed to help you pay for dependent care expenses.*
- *The maximum amount you may contribute to a Dependent Care FSA in a calendar year depends on your federal income tax filing status, whether your spouse participates in a similar plan, and the earned income of you and your spouse.*

The Dependent Care FSA is a separate Plan program that helps you pay for dependent care Eligible Expenses for your Eligible Dependents so you and your spouse (if applicable) can *work* or *look for work.* See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limit Matrix* for information that applies to you.

Dependent Care FSA Contribution Limits

The *minimum* amount you may contribute to a Dependent Care FSA in a calendar year is $100.

The *maximum* amount you may contribute to a Dependent Care FSA in a calendar year depends on:

- Your filing status for federal income tax purposes.
- Whether your spouse participates in a similar plan offered by his or her employer.
- The earned income of you and your spouse.

Limitations Based on Federal Income Tax Filing Status

The maximum amount you may contribute to a Dependent Care FSA in a calendar year is $5,000 if:

- Your filing status is single, head of household or married filing jointly.
- Your filing status is married filing separate, but only if all of the following apply:
  - You do not reside in the same household with your spouse during the last six months of the year.
  - Your home is the principal home for the dependent for whom you incur the dependent care expenses for at least six months during the year.
  - You provide more than half of the cost of maintaining your household.

The maximum amount you may contribute to a Dependent Care FSA in a plan year is $2,500 if your filing status is *married filing separate* and you reside in the same household with your spouse.

Limitations Based on Spouse's Participation in a Similar Plan

If your spouse makes contributions to a similar dependent care reimbursement account through a plan offered by his or her employer, the combined maximum amount you and your spouse may contribute to both dependent care accounts cannot exceed $5,000.

Limitations Based on Earned Income

Also, if you are married and filing a joint return, your Dependent Care FSA contribution is limited to the lesser of your earned income, your spouse's earned income or $5,000. However, if your spouse is a full-time student or is physically or mentally incapable of self-care, your spouse's monthly income is assumed to be $250 if you have one qualifying dependent, or $500 if you have two or more qualifying dependents.

If you are single, the maximum Dependent Care FSA contribution is limited to the lesser of your earned income or $5,000.

Your Dependent Care FSA

If you elect to contribute to a Dependent Care FSA, an account will be established in your name to record all of the before-tax contributions you make and the reimbursements you receive. Your Dependent Care FSA is a bookkeeping account and is not funded; all reimbursements are paid from the Company's general assets.

To be eligible for reimbursement, your dependent care expenses must be employment-related, as described in the following table.

If ...	Then ...
You are single	The care must be necessary for you to be able to work or attend school* full time.
You are married	The care must be necessary for you and your spouse to work outside the home or for you to work while your spouse is: • Looking for work. • A full-time student.** • Physically or mentally incapable of self-care.
You are divorced or separated	You must have custody of your dependent to be eligible for reimbursement from the Dependent Care FSA.

**The definition of school for Plan purposes means an educational organization that normally has a regular faculty and curriculum, and a regularly enrolled body of pupils or students in attendance at the place where its educational activities regularly are held.*

***Full-time student means a student for at least some part of each of five months during a calendar year, and for the number of hours considered to be a full-time course of study (If your spouse attends school only at night, he or she is not considered a full-time student).*

Eligible Dependents

Eligible Expenses incurred on behalf of your Eligible Dependents may be reimbursed from your Dependent Care FSA. For this purpose, your Eligible Dependents are:

- Your spouse if he/she is physically or mentally incapable of caring for himself/herself AND has the same residence as you for more than half the calendar year;
- A qualifying child who is younger than 13 (the age limitations in the qualifying child definition, below, are not applicable for this purpose); or
- A qualifying child or qualifying relative who, in either case, is physically or mentally incapable of caring for himself/herself AND has the same residence as you for more than half the calendar year.

A *qualifying child* is an individual who:

- Is your child, brother, sister, stepbrother or stepsister or the descendant of any of these individuals;
- Lives in your home for more than half of the year (temporary absences resulting from special circumstances, such as education, illness, military service, etc., will not cause an individual to lose his or her status as a qualifying child);
- Is a citizen, national or resident of the U.S. or a resident of Canada or Mexico;
- Is younger than 19 at the end of the year or is a full-time student younger than 24 at the end of the year, but there is no age limitation if the individual is totally and permanently disabled; and
- Has not provided over half of his or her own support during the year.

Eligible expenses can be reimbursed from your Dependent Care FSA for a qualifying child up to:

- Age 13;
- Age 19 (or 24 if in school) if the child is physically or mentally incapable of self-care; or
- Any age if your child is totally and permanently disabled.

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 Domestic Partner (DP) or Legally Recognized Partner (LRP) and their dependent(s) only if your DP or LRP and their dependent(s) are a qualifying child or a qualifying relative for federal income tax purposes.

Eligible Expenses

Eligible Expenses must have been incurred during the calendar year and while you are an active Participant (i.e., contributing to the Plan through payroll deductions) in the Plan to be reimbursable. An expense is incurred when the service that causes 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 incur an otherwise Eligible Expense while you are on an unpaid leave of absence, it is not reimbursable from your Dependent Care FSA since you are not an active Participant in the Plan at that time.

Dependent care expenses eligible for reimbursement from your Dependent Care FSA include the following:

- Amounts paid to a licensed care center if the care complies with local and state regulations and provides care for more than six individuals, such as a daycare center, preschool (less than kindergarten level), summer day camp or after-school care
- Costs incurred for care inside your home, such as a babysitter or home health care worker, but not for care provided by anyone considered your dependent for income tax purposes or your child younger than 19
- Amounts paid for nonresidential dependent care or nursing or custodial care, but only if your Eligible Dependent lives with you at least eight hours a day
- Costs incurred for household services related to care of a qualifying dependent
- Social Security and other taxes you pay a care provider

For more information, refer to IRS Publication 503, which may be available at your local IRS office or online at **http://www.irs.gov/pub/irs-pdf/p503.pdf.** However, you should use this IRS publication with caution because it was prepared for purposes of describing dependent care expenses that are eligible for the dependent care tax credit, not to determine which expenses are reimbursable from a Dependent Care FSA. Not all expenses eligible for the dependent care tax credit are reimbursable from a Dependent Care FSA.

Ineligible Expenses

Dependent care expenses **not** eligible for reimbursement from your Dependent Care FSA include:

- Expenses incurred before or after you participate in the Dependent Care FSA or expenses for which you were reimbursed by another plan.
- Expenses for care provided by anyone considered your dependent for income tax purposes, or by your child who is younger than 19, are not eligible for reimbursement from your Dependent Care FSA.
- Expenses for care provided by a facility that cares for more than six children if the facility is **not** licensed by state and local governments.
- Amounts you claim as a tax credit on your federal income tax return for the calendar year.
- Expenses for overnight camp expenses.
- Expenses for a child after the end of the month in which the child turns age 13, or age 19 (age 24, if in school) if the child is physically or mentally incapable of self-care.
- Expenses for transportation to and from your dependent care provider.
- Tuition expenses for kindergarten level and above.
- Expenses for a finder's fee for placement of a nanny or au pair.

> Note: If you receive reimbursement for an ineligible expense from your Dependent Care FSA, you are responsible for repaying the money.

For more information, refer to IRS Publication 503, which may be available at your local IRS office or online at **http://www.irs.gov/pub/irs-pdf/p503.pdf.**

How to File Dependent Care FSA Claims for Reimbursement

All Claims for reimbursement from your Dependent Care FSA must be submitted in writing. Follow these steps to file a Claim for reimbursement from your Dependent Care FSA.

1. Pay the expense by its due date. Do not wait to pay the expense until you receive your reimbursement from your Dependent Care FSA.
2. Enter your claim online (or through the mobile application) or by calling to request a paper claim form (see the *Claims Administrator* table in the "Contact Information" section for contact information).
3. Provide a receipt or an itemized statement with dates of services from the provider. You must include the signature and the tax identification number (or Social Security Number of your dependent care provider) on the form. The completed form will serve as your dependent care receipt.
4. Complete and submit your Claim and receipt(s) online or to the address on the bottom of the form, or print a cover sheet, sign-it and then fax it to the number provided on the form (see the *Claims Administrator* table in the "Contact Information" section for contact information).
5. Be sure to keep a copy of the receipt and, if applicable, your form, in case you need to provide more information about your Claim.
6. The Claims Administrator must receive your claim and receipts/complete documentation by March 31 of the year after the year in which you incurred the Eligible Expense and contributed to your Dependent Care FSA.

Payments From Your Dependent Care FSA

Available Reimbursement Amounts

The amount available for reimbursement from your Dependent Care FSA at any time throughout the Plan Year is limited to the total amount contributed to your Dependent Care FSA at the time of your Claim, *less* any reimbursements you already received for that Plan Year. If your Claim is for more than your account balance, you will be reimbursed as additional contributions are made to your account.

You **cannot** carry over a balance in your Dependent Care FSA from one Plan Year to the next. If you have **not** incurred enough eligible expenses by Dec. 31 to claim all deposits made to your Dependent Care FSA, the law requires you to forfeit any remaining money.

All Claims for eligible expenses incurred while a Participant during the prior Plan Year must be received by the Claims Administrator on or before March 31 of the following year.

Dependent Care FSA forfeitures and uncollected Dependent Care FSA benefits will be used to reduce Plan administration costs.

Reimbursement by Check

After your Claim for reimbursement is processed and approved, the Claims Administrator will send you a reimbursement check, up to the amount of your elected amount reduced by any reimbursements you have already received. Your reimbursement check is generally mailed within

two to three days of Claim approval. Your reimbursement check will be attached to an Explanation of Benefits (EOB) detailing the Claim payment.

> Note: Issued check payments are valid for six months (180 days) from the date on the check. If not cashed within six months of issuance, the check expires and are stale voided. To have a check payment reissued, contact the AT&T Benefits Center.

Reimbursement by Electronic Funds Transfer

Alternatively, you can have your reimbursement amount electronically deposited directly into your checking or savings account. With electronic funds transfer (EFT), you can begin receiving Claim payments within a few days after your Claim is processed. If you provide the Claims Administrator with your email address, you will receive updates on reimbursement activity and account activity statements. With email communications, you can receive a complete EOB statement (total expense paid, partial payment or full denial) whenever a Claim is processed.

To participate in EFT, you may elect direct deposit on the Claims Administrator's website or by calling the Claims Administrator. The "Contact Information" section includes the phone number and address for the Claims Administrator.

Dependent Care Tax Credit

The Dependent Care Tax Credit is a credit against your federal income tax liability. This credit is calculated as a percentage of your eligible annual dependent care expenses. To determine what your tax credit would be, you may use $3,000 of such Eligible Expenses for one dependent or $6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35 percent of your qualifying expenses (to a maximum credit of $1,050 for one dependent or $2,100 for two or more dependents). The maximum 35 percent rate is reduced by 1 percent (but not below 20 percent) for each $2,000 (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000. The minimum credit for Eligible Expenses relating to one dependent is $600 and $1,200 for two or more dependents.

You may not claim a tax credit on your federal income tax return for any dependent care expenses reimbursed through your Dependent Care FSA.

The maximum amount of Dependent Care Tax Credit you may claim is reduced, dollar-for-dollar, by amounts contributed to your Dependent Care FSA. The amount contributed is reported on your W-2 form, although it is not included as taxable income.

While generally a Dependent Care FSA provides greater tax advantages than the Dependent Care Tax Credit, you should talk to a tax advisor about the specific advantages and disadvantages of each. Refer to IRS Publication 503, which may be available at your local IRS office or online at **http://www.irs.gov/pub/irs-pdf/p503.pdf.**

HOW TO FILE A CLAIM AND APPEAL UNDER THE PLAN

KEY POINTS

- *You may file a Claim if you do not agree with the way your participation in, or benefits under, the Plan are administered.*
- *A Claim regarding your request for reimbursement from your Health Care FSA or your Dependent Care FSA must be filed with the Claims Administrator. All other Claims under the Plan must be filed with the Eligibility and Enrollment Vendor.*
- *A denied Claim may be appealed within 180 days after receipt of the denial notice.*
- *You must pursue all of your Claim and Appeal rights under the Plan before seeking legal recourse in a court of law.*

Claim Filing Procedures

Your Claim for Benefits is reviewed and determined by the Claims Administrator, which is either the Claims Administrator or the Eligibility and Enrollment Vendor, depending on the nature of your Claim.

Health Care FSA and/or Dependent Care FSA Reimbursement Claims

Claims for reimbursement, from your Health Care FSA or Dependent Care FSA, must be submitted to the Claims Administrator. In general, Health Care FSA claims will be submitted through automatic claims processing from a Participating Benefits Administrator. You can log on to the website (or the mobile application) and upload your receipts to file a claim electronically, if you use a non-Participating Benefits Administrator. Forms may also be obtained from the Claims Administrator. Claims and receipts for reimbursement must be submitted to the Claims Administrator by fax, mail, mobile application or online claims submission. See the "How to File Health Care FSA Claims for Reimbursement" or "How to File Dependent Care FSA Claims for Reimbursement" sections for more information. See the "Contact Information" section for contact information on the Claims Administrator.

All Other Claims

All Claims that do **not** relate to reimbursement from your Health Care FSA or Dependent Care FSA must be submitted in writing (by mail or fax) to the Eligibility and Enrollment Vendor. These include Claims relating to BTPO, HSA Payroll Contributions, eligibility, enrollment or participation in any part of the Plan, and Plan election changes.

HSA claims are **not** governed by this Plan's claims and appeal procedures. Claims relating to the maintenance or administration of an HSA established and maintained outside the Plan are administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and your trustee/custodian. See the "Contact Information" section for information on how to contact the administrator accepting HSA Payroll Contributions from the Company.

If the Eligibility and Enrollment Vendor denies your enrollment or participation in the Plan on the basis of ineligibility or denies your request to change your BTPO, HSA Payroll Contribution, Health Care FSA or Dependent Care FSA elections, you may call or send written correspondence to the Eligibility and Enrollment Vendor to attempt to resolve the issue. See the "Contact Information" section for the Eligibility and Enrollment Vendor's contact information. If the issue is not resolved

to your satisfaction, you may file a written Claim for Eligibility. You may use a form provided by the Eligibility and Enrollment Vendor for this purpose.

Processing Your Claim

Health Care FSA and/or Dependent Care FSA Reimbursement Claims

Once you submit your Claim (auto claims submission, online claim, mobile application claim or paper claim using the form received from the Claims Administrator), including any supporting documentation, the Claims Administrator will notify you of its decision within 30 days after the date your Claim is received. The Claims Administrator may extend this period once (for up to 15 days) if it determines that special circumstances require more time to determine your Claim. You will be notified, within the initial 30-day period, if additional time is needed and of the special circumstances that necessitate the extra time. If an extension is required because the Claims Administrator needs additional information from you, you will have 45 days from the date you receive notification to provide that information. Once you have provided the information, the Claims Administrator will decide your Claim within the time remaining in the initial or extended review period of 30 or 45 days, whichever is applicable. If you do not respond to the request for information, your Claim for Eligibility is denied, but you may appeal this decision.

You may check the status of a Claim via letter or telephone at any time. However, these inquiries are not considered formal appeals. It is not necessary to make an informal inquiry before filing an Appeal.

All Other Claims

Once you submit your written Claim, including any supporting documentation, the Eligibility and Enrollment Vendor will notify you of its decision within 30 days after the date your Claim is received. 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 determine your Claim. You will be notified within the initial 30-day period if additional time is needed and of the special circumstances that necessitate the extra time. If an extension is required because the Eligibility and Enrollment Vendor needs additional information from you, you will have 45 days from the date you receive notification to provide that information. Once you have provided the information, the Eligibility and Enrollment Vendor will decide your Claim within the time remaining in the initial or extended review period of 30 or 45 days, whichever is applicable. If you do not respond to the request for information, your Claim for Eligibility is denied, but you may appeal this decision.

If Your Claim Is Denied

If your Claim is approved, you will receive notice from the Claims Administrator/Eligibility and Enrollment Vendor. If your Claim is denied in whole or in part, you will be provided with a written denial notice from the Claims Administrator/Eligibility and Enrollment Vendor. A written denial notice will contain:

1. Information sufficient to identify your Claim.
2. Specific reason(s) for the denial.
3. Specific reference(s) to the Plan provisions, the law, or applicable regulatory guidance on which the denial is based.
4. If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied on in making the determination, and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.

5. If applicable, a description of any additional information needed to make your Claim acceptable and the reason the information is needed.
6. A description of the Plan's Appeal procedures.
7. A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to Appeal under the Plan.

How to Appeal a Denied Claim

If your Claim is denied and you disagree with the decision, you may appeal the decision by filing a written request for review. You or your authorized representative must file a written Appeal within 180 days from receiving the denial notice.

Your appeal is reviewed and determined by the Eligibility and Enrollment Vendor, Claims and Appeals Management or the Eligibility and Enrollment Appeals Committee (EEAC) depending on the nature of your appealed Claim.

Appeal of Denied Health Care FSA and/or Dependent Care FSA Reimbursement Claims

Your appeal of a denied Claim for reimbursement from your Health Care FSA or Dependent Care FSA must be submitted, in writing, to Claims and Appeals Management. Appeal forms may be obtained by calling the Claims Administrator. Appeals may be submitted by mail to Claims and Appeals Management (See the "Contact Information" section for contact information).

You can file a written Appeal if your Claim is denied (in whole or in part). To file an Appeal, you must send a written summary to the Claims Administrator with the following information:

- Your name
- Patient's name
- Date(s) of service
- Provider's name
- A summary of the issue, including the reason you believe the Claim for Benefits should be paid, and
- All relevant documents, such as letters, Explanation of Benefits (EOBs), and statements.

The Appeal will take into account all comments, documents, records and other information you submit related to the Claim for Benefits, without regard to whether the information was submitted or considered in the initial benefit determination. If you wish, you or your authorized representative may review the appropriate Program documents and submit written information supporting your Claim for Benefits to the Claims Administrator or Plan Administrator.

If the Program fails to meet the time requirements of the Claim and Appeals process for your Claim for Benefits, your Claim for Benefits is deemed denied and you may pursue your Claim for Benefits in a civil action under ERISA. See the "Contact Information" section for the Claims Administrator's contact information.

Appeal of Denied Claim Regarding BTPO or HSA Payroll Contributions

Your appeal of a denied Claim relating to your BTPO or HSA Payroll Contribution must be submitted, in writing along with any supporting documentation, to the Eligibility and Enrollment Vendor (see the "Contact Information" section).

Appeal of Denied Claim for Eligibility or Participation in the Plan

Your appeal of a denied Claim relating to eligibility or participation in any part of the Plan must be submitted, in writing along with any supporting documentation, to the EEAC at:

AT&T Eligibility and Enrollment Appeals Committee
Attn: Claims and Appeals Management
P.O. Box 1407
Lincolnshire, IL 60069-1407

If you or your authorized representative sends a written request for review or Appeal of a denied Claim, you or your representative has the right to:

1. Send a written statement of the issues and any other comments, along with any new or additional evidence or materials, in support of your Appeal.
2. Request and receive, free of charge, documents that bear on your Claim, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Claim.
3. Reasonable access to, and copies of, all documents, records and other information relevant to your Claim.
4. In your Appeal, you should state, as clearly and specifically as possible, any facts that you think are relevant to your Appeal.
5. Your Appeal must also state, as clearly and specifically as possible, all issues that relate to your Claim and all reasons why you believe the Claims Administrator's action is incorrect.
6. An Appeal regarding your eligibility or participation in the Plan will be reviewed and determined by members of the EEAC who were not involved in the decision to deny your initial Claim.

Scope of Review — Appeal of Claim

During its review of an Appeal of a denied Claim, the Appeals reviewer will:

- Take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim.
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents.
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the Claimant in a manner consistent with how such provisions have been applied to other similarly situated Claimants.
- Each of the Appeal reviewers has the sole and complete discretionary authority to interpret and administer the applicable Plan provisions. This includes the power and authority to determine all relevant facts and resolve issues relating to the interpretation and construction of all relevant Plan terms as they relate to Claims that they review, consider, and determine. Each Appeal reviewer's decisions are conclusive and binding, and are not subject to further Plan review.

If the Appeal of your Claim is denied, it is final and is not subject to further review. However, you may have further rights under ERISA, as provided in the "ERISA Rights of Participants" section below.

IMPORTANT: You must pursue all of your Claim and Appeal rights under the Plan before seeking legal recourse in a court of law.

Decisions on Appeals Involving Claims

The decision on Appeal of the denied Claim will be communicated in writing to the Claimant within 30 days of the Appeal reviewer's receipt of the Appeal. If the Appeal is denied, the Appeals reviewer will provide written notification to the Claimant which will include all of the following:

1. The specific reason or reasons for the Adverse Benefit Determination
2. Specific reference to pertinent Plan provisions on which the Adverse Benefit Determination was based
3. The contents of any internal rule, guideline, protocol or other similar criterion relied upon in making the Adverse Benefit Determination; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request
4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim for Benefits
5. A statement of the Claimant's right to bring a civil action under ERISA Section 502(a).

Appeal Review – Reimbursement Appeals

Your reimbursement Appeal will be assigned to a qualified individual or committee who has had no involvement with the denial of your Claim for Benefits. The Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Program in connection with your Claim, as well as any new or additional rationale to be used in reaching the decision. You will be given this information in advance of the date on which the notice of final Appeal decision is made to give you a reasonable opportunity to respond.

Claim Appeals Review Process – Reimbursement Appeals

You will be notified by the Claims Administrator of its decision on your Appeal within a reasonable period of time, but not later than 30 days from receipt of a request for Appeal of a denied Claim for reimbursement. If you are not satisfied with the first-level Appeal decision, you have the right to request a second-level Appeal. You must submit your second-level Appeal request to the Claims Administrator in writing within 180 days from receiving the first-level Appeal decision. The second-level Appeal will be conducted, and the Claims Administrator will notify you of the decision within a reasonable period of time, but not later than 30 days from receiving the request for review of the first-level Appeal decision.

The Company has delegated to Claims and Appeals Management the exclusive right to interpret and administer Program provisions related to reimbursements. The decision of Claims and Appeals Management on a Claim for reimbursement is conclusive and binding.

Note: The Benefits Administrator's decision is based only on whether or not Benefits are available and the amount of Benefits under the Program for the proposed treatment or procedure.

PLAN ADMINISTRATION

Plan Administrator

The Plan Administrator is the named fiduciary of the Plan with the power and duty to do all things necessary to carry out the Plan's terms. The Plan Administrator has the sole and absolute discretion to interpret Plan provisions, make findings of fact, determine the rights and status of Participants and others under the Plan, decide disputes under the Plan and delegate all or a part of its 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 Plan purposes.

Administration

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

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

Nondiscrimination in Benefits

The Code does not allow discrimination in favor of highly compensated Participants or key Employees with regard to some of the Plan's benefits. The Plan Administrator may restrict the amount of nontaxable benefits provided to key Employees or highly compensated Participants so that these nondiscrimination requirements are satisfied.

Plan benefits will not discriminate in any of the following ways:

- On the basis of any health factor, including evidence of insurability.
- As to eligibility for benefits, on the basis of a health factor.
- On the basis of premiums or contributions for similarly situated individuals.

Amendment or Termination of the Plan

AT&T Inc. intends to continue the Plan described within this SPD but reserves the right to amend or terminate the Plan or to amend or eliminate Plan benefits at any time. In addition, your Participating Company reserves the right to end its participation in the Plan. 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 Plan. However, no Plan amendment or termination will diminish or eliminate any Claim for a benefit to which you may have become entitled before such amendment or termination, unless the termination or amendment is necessary for the Plan to comply with the law.

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

Limitation of Rights

Participation in the Plan does not give you a right to remain employed by the Company. Except as otherwise required by law or as allowed under the provision of the Plan, Plan benefits may not be assigned or alienated. This means that you may not sell, assign, pledge or otherwise transfer Plan benefits before the benefits are paid to you, nor are your Plan benefits subject to attachments, garnishment, execution or encumbrance of any kind before payment to you.

Legal Action Against the Plan

If you wish to bring a legal action concerning your right to participate in the Plan or your right to receive Plan benefits, you must first exhaust the Claim and Appeals process described in this SPD. A legal action should not be filed until you complete 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 Plan should be filed directly against the Plan. Process in legal actions concerning the provision of Plan benefits should be served on the Plan Administrator as provided in the *Other Plan Information* table.

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, Plan administration or trust fund operation or investment responsibilities are delegated, including but not limited to, members of any committees and their delegates responsible for Plan 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 Plan, 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.

OTHER PLAN INFORMATION

Other Plan Information	
Plan Name	AT&T Inc. Flexible Spending Account Plan (AT&T FSA), which includes the • Before-Tax Premium Option (BTPO) • Before-Tax Health Savings Account (HSA) Payroll Contributions • Health Care Flexible Spending Account (Health Care FSA or HCFSA) • Dependent Care Flexible Spending Account (Dependent Care FSA or DCFSA)
Plan Number	533

Other Plan Information	
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**
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 Plan as follows • The Plan Administrator administers Claims and Appeals for Plan benefits on a contract basis with the Benefits Administrator, see the "Contact Information" section for more information. The Benefits Administrator has full discretionary authority to interpret Plan provisions as they apply to entitlement for benefits. • The Plan Administrator administers enrollment, eligibility, monthly contributions and COBRA under the Plan provisions, including the determination of initial Claims for Eligibility and appeals for Claims for Benefits involving eligibility, on a contract basis with the AT&T Benefits Center, see the "Contact Information" section for more information. • 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 System 1999 Bryan Street, Suite 900 Dallas, TX 75201-3136
Type of Plan	Welfare benefit plan that constitutes a cafeteria (salary redirection) plan organized under Section 125 of the Code.

Other Plan Information	
Plan Year	Jan. 1 - Dec. 31
Plan Funding and Contributions	The Plan is funded solely through salary reductions. The amounts payable under this Plan will be paid solely from the general assets of the Company. 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. There is no trust that has been created to hold Employee contributions to these Plans.
Plan Records	All Plan records are kept on a calendar year basis beginning Jan. 1 and ending Dec. 31.
Collectively Bargained Plan	For certain Eligible Employees, the Plan is maintained through one or more collective bargaining agreements. Upon written request to the Plan Administrator, a copy of these collective bargaining agreements may be obtained by Participants who are eligible to participate in the Plan as a result of such collective bargaining agreements, or may be examined by such Participants as required pursuant to DOL Regulations Sections 2520.104b-1 and 2520.104b-30.

ERISA RIGHTS OF PARTICIPANTS

KEY POINTS

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

Your ERISA Rights as a Participant

The BTPO and HSA Payroll Contributions provisions of this Plan are not governed by the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health Care FSA and the Dependent Care FSA are subject to ERISA. As a Participant in either the Health Care FSA or the Dependent Care FSA, you are entitled to certain rights and protections under ERISA, including:

- To receive information about the Plan 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 Plan, including collective bargaining agreements, and a copy of the latest annual reports (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 "Assistance With Your Questions" section.
- To obtain copies of documents governing Plan operation, 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, Texas 75313-2160

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

- Continue Health Care FSA contributions if there is a loss of Plan coverage as a result of a Qualifying Event (see the "Extension of Coverage – COBRA" section). You 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 Plan. The people who operate the Plan, called fiduciaries, have a duty to act prudently and in the interest of you and other Participants. No one, including your Employer, any union or any other person, may fire you or otherwise discriminate against you to prevent you from obtaining a Plan 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 Plan 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 Plan that is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 Plan, 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. N.W.
Washington, DC 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 Health Care FSA participation when participation would otherwise end due to a Qualifying Event. You may not continue your BTPO, HSA Payroll Contribution, or Dependent Care FSA under COBRA.*
- *You may elect and pay for Health Care FSA COBRA continuation coverage to avoid forfeiting any unused amount in your account at the time your participation would otherwise end.*
- *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 Health Care FSA 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 re-enroll.*

COBRA Continuation Coverage

If your Plan participation ends due to a Qualifying Event, you may elect to continue Plan participation and receive the same coverage you had under the Plan 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 Health Care FSA account and to continue to receive reimbursements to your account, the same as for similarly situated Eligible Employees. If you do not elect COBRA continuation coverage, you have until March 31 of the year following the current year to submit Claims for Eligible Expenses incurred while you were a Participant.

Federal law requires most employers sponsoring group health plans to offer Employees and their Eligible Dependents the right to elect a temporary extension of Health Care FSA coverage (referred to as continuation coverage or COBRA continuation coverage) in certain instances when coverage under your Health Care FSA would otherwise end.

This section generally explains COBRA continuation coverage for your Health Care FSA, when it may become available to you and your family, 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 Health Care FSA participation when participation would otherwise end due to a Qualifying Event. You may **not** continue your BTPO, HSA Payroll Contributions, or Dependent Care FSA under COBRA. Qualifying Events are listed later in this section. After a Qualifying Event occurs, and any required notice is provided to the COBRA Administrator, Health Care FSA COBRA continuation coverage must be offered to a Qualified Beneficiary, provided you have a positive Health Care FSA balance at the time of the Qualifying Event (taking into account all Claims submitted before the date of the Qualifying Event). A Qualified Beneficiary can choose to elect and pay for Health Care FSA COBRA continuation coverage to avoid forfeiting any unused Health Care FSA amounts at the time your participation or coverage would otherwise end.

You are a Qualified Beneficiary if you lose coverage under the Health Care FSA due to a Qualifying Event. Your spouse and dependents whose medical expenses are reimbursable under the Health Care FSA are each a Qualified Beneficiary if, due to a Qualifying Event, you lose coverage or their medical expenses are no longer reimbursable under the Health Care FSA. Only a Qualified Beneficiary may elect to continue their Health Care FSA coverage under COBRA. A Qualified Beneficiary who elects Health Care FSA COBRA continuation coverage must pay for COBRA continuation coverage.

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

COBRA Qualifying Events: When Is COBRA Coverage Available?

Eligible Employee

If you are a Participant in the Plan, you become a Qualified Beneficiary and have the right to elect Health Care FSA COBRA continuation coverage if you lose coverage under the Plan and you have a positive Health Care FSA balance at the time of the Qualifying Event because one of the following Qualifying Events occurs:

- Your employment ends for any reason other than your gross misconduct.
- Your hours of employment are reduced.

Spouse

If your spouse is covered by the Health Care FSA, your spouse will become a Qualified Beneficiary and have the right to elect continuation coverage if your spouse loses Plan coverage because any of the following Qualifying Events occurs:

- You die.
- Your employment ends for any reason other than your gross misconduct or your hours of employment with the Participating Company are reduced.
- You become divorced or legally separated from your spouse.

Note: If you eliminate coverage for your spouse 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 ex-spouse lost coverage earlier. If your ex-spouse notifies the Eligibility and Enrollment Vendor within 60 days after the later of the divorce or legal separation or the date coverage terminates 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 Health Care FSA eligibility or the dependent stops being an Eligible Dependent whose expenses are no longer reimbursable under the Health Care FSA because one of the following Qualifying Events occurs:

- You or your spouse die.
- Your employment ends for any reason other than your gross misconduct or your hours of employment with the Participating Company are reduced.
- You and your spouse divorce or legally separate.
- The child ceases to be an Eligible Dependent child under the Health Care FSA.

FMLA

Special COBRA rules apply if you take an FMLA leave and do not return to work at the end of the leave. Failure to return to work at the end of an FMLA leave may constitute a Qualifying Event (i.e., You may elect Health Care FSA COBRA continuation coverage). In this case, you and your spouse and/or dependents, if any, will be able to elect Health Care FSA COBRA continuation coverage if you were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave).

As a result, you may elect COBRA continuation coverage to be effective on the day after the date on which your employment ends (even if your coverage ended during a leave) if you were both:

- Covered under the Plan on the day before beginning the leave of absence.
- Terminated from employment within the first six months of the leave for any reason except your gross misconduct.

Important Notice Obligations

The Plan will offer Health Care FSA COBRA continuation coverage to you or a Qualified Beneficiary only after the Eligibility and Enrollment Vendor has been timely notified that a Qualifying Event has occurred.

Your Employer's Notice Obligations

When the Qualifying Event is the end of your employment, the reduction in your hours of employment, or your death while employed, the Company will notify the Eligibility and Enrollment Vendor of the Qualifying Event within 30 days of the event. The Eligibility and Enrollment Vendor will then notify your Qualified Beneficiary of their right to elect COBRA continuation coverage.

Your Notice Obligations

For a Qualifying Event other than the end of your employment, the reduction in your hours of employment, or your death while employed, 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 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 there is a positive Health Care FSA balance at the time of the Qualifying Event. If you or the Qualified Beneficiary timely elects COBRA continuation coverage, the coverage will begin on the date that the Plan coverage would otherwise end.

COBRA Notice and Election Procedures

A COBRA election must be made with the Eligibility and Enrollment Vendor within the time frames specified below.

IMPORTANT: COBRA Notice and Election Procedures

You must notify the Eligibility and Enrollment Vendor 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 summaries of material modifications. 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 your name and address and last four digits of your Social Security number, and the name(s) and address(es) and last four digits of the Social Security number of any affected Qualified Beneficiary. If the notice concerns a Qualifying Event, the notice must also identify the Qualifying Event and 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 Plan 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 Plan. For example, your spouse 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. The amount may not exceed 102 percent of the cost of coverage under the Health Care FSA, which is generally 102 percent of the amount the Employee elected to contribute to the Health Care FSA, less any reimbursements already paid.

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 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. Health Care FSA Claims for reimbursement may not be processed and reimbursed until you have elected COBRA continuation coverage and have made the first payment. Any amounts reimbursed from your Health Care FSA 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 by 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. Health Care FSA COBRA continuation coverage will end on the last day of the calendar year and **cannot** be continued the next calendar year.

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

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

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

IMPORTANT NOTICES ABOUT YOUR BENEFITS

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

Qualified Medical Child Support Orders

The Plan 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 Employee who is recognized by a medical child support order as having a right to enrollment under an Eligible Employee'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 Plan'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 Plan will comply with the QMSCO provisions. If a QMCSO is issued for your Child with respect to the Plan and you are eligible but not participating in the Plan at that time, you and your Child will be enrolled in the applicable provisions of the Plan in accordance with its terms and pay any required contributions.

Newborn's 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 Plan or the issuer for prescribing a length of stay not exceeding 48 (or 96) hours.

HIPAA Provisions for the Health Care FSA

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 Plan. You may also view or print a copy of the Plan'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 requesting a copy from the Claims Administrator identified in the "Contact Information" section.

A limited number of Company Employees may have access to a Participant's individually identifiable health information for administering the Health Care FSA. 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 PHI.

Protected Health Information (PHI) means information created or received by the Plan and 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 of persons living or deceased.

The Company shall have access to PHI relating to the Health Care FSA only as permitted under the Plan or as otherwise required or permitted by HIPAA.

- The Health Care FSA may disclose to the Company information on whether an individual is participating in the Health Care FSA.
- The Health Care FSA 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 Health Care FSA. Summary Health Information (SHI) 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 Plan, the Health Care FSA may disclose PHI to the Company for Plan administration purposes only. Plan administration purposes means administration functions performed by the Company on behalf of the Health Care FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration 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 any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health Care FSA, the Company shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health Care FSA, 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 Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan of which it becomes aware;

- Make available PHI to comply with HIPAAs 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 Health Care FSA available to the Secretary of Health and Human Services to determine compliance by the Health Care FSA with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Health Care FSA 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 Health Care FSA 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 Health Care FSA, 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 agree to implement reasonable and appropriate security measures to protect the information. The Company will report to the Health Care FSA 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 Health Care FSA (and their superiors, who have a need to know such information), including payroll staff performing Health Care FSA functions, members of the Eligibility and Enrollment Appeals Committee (EEAC), and any other Employee who needs access to PHI in order to perform Plan administration functions that the Company performs for the Health Care FSA (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 plan administration functions that the Company performs for the Health Care FSA. If any of these specified Employees does not comply with the Plan's provisions, 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
Type	FSA Claims and Appeals
Services Provided	To request reimbursements or for Claims or Appeals related to reimbursements.
Vendor Contact Numbers	
Contact Numbers Information	Contact the Claims Administrator at:
Domestic Telephone Number	**877-722-0020**
International Telephone Number	**847-883-0866**
Hearing Impaired Telephone Number	From a TTY phone dial **711** From any other phone dial **800-877-8973**
Vendor Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7 a.m. to 7 p.m. Central time. **IVR System:** The interactive voice response system is available 24 hours a day, seven days a week.
Vendor Website	
Website Access Information	**IMPORTANT:** To access the website you will need your ID and password.
Website	**att.com/benefitscenter**
Vendor Mailing Address	
General Mailing Address	
Mailing Address Information	General questions about the Plan may be sent to:
Domestic	Your Spending Account P.O. Box 64030 The Woodlands, TX 77387-4030
Claims	
Claims Information	Written Claims for reimbursement/benefits or an Appeal of a denied Claim for reimbursement/benefits under the Plan **must** be sent to:

Contact Information	
Claims Regular	Your Spending Account P.O. Box 64030 The Woodlands, TX 77387-4030
Claims Overnight	FAX number **(888-211-9900)**
Appeals	
Appeals Information	Written Appeals for reimbursement/benefits or an Appeal of a denied Claim for reimbursement/benefits under the Plan **must** be sent to:
Appeals Regular	Your Spending Account Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407
Appeals Overnight	FAX number **(847-554-1397)**
Vendor Special Instructions	
Instructions	Reimbursement Claims with receipts can be submitted via the Mobile App, Website or Paper Claim Form by fax or mail.

Contact Information	
Vendor	
Name	AT&T Benefits Center
Type	Eligibility, Enrollment, BTPO, and HSA (payroll contributions only)
Services Provided	To enroll, make changes to employee contributions or qualified status changes, contact the AT&T Benefits Center below.
Vendor Contact Numbers	
Contact Numbers Information	Contact the Eligibility and Enrollment Vendor 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 7 p.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).

Contact Information	
Vendor Website	
Website Access Information	**IMPORTANT:** To access the website you will need your AT&T Benefits Center ID and password.
Website	**att.com/benefitscenter**
Vendor Mailing Address	
General Mailing Address	
Mailing Address Information	General questions about the Plan may be sent to:
Domestic	AT&T Benefits Center P.O. Box 1407 Lincolnshire, IL 60069-1407
Claims	
Claims Information	Written claims for BTPO, eligibility and enrollment under the Plan **must** be sent to:
Claims Regular	AT&T Benefits Center Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407
Claims Overnight	AT&T Benefits Center Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407
Appeals	
Appeals Information	Written appeals for BTPO, eligibility and enrollment under the Plan **must** be sent to:
Appeals Regular	AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 1407 Lincolnshire, IL 60069-1407
Appeals Overnight	AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 1407 Lincolnshire, IL 60069-1407

Contact Information	
Vendor	
Name	Fidelity Investments
Type	HSA Payroll Contributions
Services Provided	HSA vendor that AT&T will automatically forward before-tax HSA Payroll Contributions.
Vendor Contact Numbers	
Contact Numbers Information	Contact Fidelity Investments
Domestic Telephone Number	**800-416-2363**
Vendor Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7:30 a.m. to 11 p.m., excluding some holidays. **IVR System:** The interactive voice response system is available 24 hours a day, seven days a week.
Vendor Website	
Website Access Information	To access the website use this address:
Website	**www.netbenefits.com/att**
Vendor Mailing Address	
General Mailing Address	
Mailing Address Information	General questions about an HSA may be sent to:
Domestic	Fidelity Investments P.O. Box 770001 Cincinnati, OH 45277-0036
Claims	
Claims Information	Contact Fidelity Investments for claims assistance. The HSA offered by Fidelity Investments is not an arrangement established or sponsored by the Company. It is the Company's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.
Claims Regular	Fidelity Investments P.O. Box 770001 Cincinnati, OH 45277-0036
Claims Overnight	Fidelity Investments 100 Crosby Parkway Covington, KY 41015-4325

New Mobile Application – For Android and Iphones. Find it in the App. Store of your Mobile device
ReimburseMe (Free App)

INFORMATION CHANGES AND OTHER COMMON RESOURCES

Active Employee Address and Telephone Number Changes	
It's important to keep your work and home addresses current because the majority of your benefits, Payroll or similar information is sent to these addresses. Please include any room, cubicle or suite number that will help make mail routing more efficient.	
For Employees with access to the Employee intranet:	
***eLink* Users**	**Home and work address updates:** • Go to **access.att.com** log-in using your Global Log-in and then click the Learn More button under the HROneStop button and then select E on the Quick Reference tab and select eLink (eCORP) Login. • On the eCORP home page, click on Employee Services. Note: Please be sure the far right-hand scroll bar is all the way to the top. • Select Overview. • To update your home address, select Edit at the top of the Permanent Residence box, make any necessary changes and click Save. • To update your work address, select Edit at the top of the Work Location box, make any necessary changes and click Save. **For Employees without access to the Employee intranet:** • Contact your supervisor or eLink assistant

AT&T Benefits Intranet and Internet Access
Your Health Matters Section of HROneStop (Active Employees only) • Go to the *Your Health Matters* section of **HROneStop,** by clicking the *Quick Reference* tab > *Y* > *Your Health Matters.*
Your Health Matters section of access.att.com (Active Employees from home) - HROneStop Go to the Your Health Matters section of **access.att.com** (AT&T's secure Internet site) log-in using your Global Log-in and then click the Learn More button under the HROneStop button then see the Your Health Matters section 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 Active Employee is an Employee who is on the Payroll (whether or not actually receiving pay) and who is performing services for his or her employer.

Adverse Benefit Determination. An Adverse Benefit Determination is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit, including any such denial, reduction, termination of, or failure to provide or make a payment that is based on a determination of a Participant's eligibility to participate in the Plan.

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

AT&T Medical Program. AT&T Medical Program is an option under AT&T Umbrella Benefit Plan No. 3 that provides health care benefits to Eligible Employees that participate in this Plan.

Bargained Employee. Means 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.

Before-Tax Premium Option (BTPO). The BTPO under the Plan enables Eligible Employees to pay contributions for Company-sponsored health care plans and certain welfare plans on a before-tax basis.

Child(ren). Refer to the applicable *Eligible Dependent* definition in the Health Care FSA or the Dependent Care FSA sections, as applicable, for the definition of Child(ren).

Claim. A Claim is a Claim for Benefits or a Claim for Eligibility.

Claim for Benefits. A Claim for Benefits is a written request for benefits under the Plan. A request concerning enrollment or eligibility shall not be considered a Claim for Benefits unless the Claimant's eligibility is a basis for the denial of a request for the payment of benefits under the Plan.

Claim for Eligibility. A Claim for Eligibility is a written request for enrollment or change to the Participant's enrollment.

Claimant. A Claimant means a Participant or the Participant's authorized representative, who has submitted a Claim for Benefits under the Plan.

Claims Administrator. A Claims Administrator is any third-party administrator, insurance company or other organization or individual to which the Company or the Plan Administrator has delegated the duty to process and/or review Claims for Benefits or Claims for Eligibility under the Plan. If no separate Claims Administrator has been designated by the Company or the Plan Administrator, the Plan Administrator will be the Claims Administrator for the Plan.

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. 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. AT&T Inc. and its subsidiaries and affiliates that are Participating Companies or any successor or successors thereof.

Dependent Care Flexible Spending Account (Dependent Care FSA). The Dependent Care FSA is a separate program under the Plan that offers certain Eligible Employees the opportunity to pay, on a before-tax basis, for certain anticipated dependent care expenses incurred so that the Eligible Employee and his or her spouse, if applicable, can work outside the home.

Dependent Care Tax Credit. See the "Dependent Care Tax Credit" section for information about the provisions of the Dependent Care Tax Credit.

Eligibility and Enrollment Appeals Committee (EEAC). The committee appointed by the Company to make the final determination on eligibility, change in status and enrollment 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 responsibility under the Plan for eligibility determinations, enrollment administration, cost of coverage information, billing, COBRA administration, change of status event administration and the provision of general benefits information to Participants.

Eligibility Waiting Period. The Eligibility Waiting Period is the period after an Eligible Employee becomes employed by a Participating Company before he or she is eligible to enroll in the Plan. See "Appendix B" *Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limit Matrix*.

Eligible Contributions. Eligible Contributions are before-tax contributions made under the Plan's BTPO option.

Eligible Dependent. See the Eligible Dependent definition in the "Health Care FSA" or the "Dependent Care FSA" section of the Plan for an explanation as to who qualifies as an Eligible Dependent under each of the Health Care FSA and the Dependent Care FSA.

Eligible Employee. An Eligible Employee is an Active Employee of a Participating Company who satisfies the conditions for eligibility to participate in the Plan as described in the "Eligibility and Participation" section.

Employee. An Employee is 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 Participating Company.

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

Explanation of Benefits. An Explanation of Benefits (EOB) is a statement you receive after a benefits administrator has processed your Claim. The EOB shows the expenses submitted for payment, the allowable charge for Eligible Expenses, the amount of Benefits payable, and any amounts you must pay.

FMLA. FMLA is 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 a common-law Employee and 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.

Fully-Insured Managed Care Option. Is an option that may be available under the AT&T sponsored medical program that you may participate in and that provides benefits under an insured arrangement and not through a Company self-funded arrangement.

HIPAA. HIPAA is the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time.

Health Care Flexible Spending Account (Health Care FSA). The Health Care FSA is a Plan option that offers certain Eligible Employees the opportunity to pay, on a before-tax basis, for certain out-of-pocket health care expenses not covered by a health care plan.

Health Reimbursement Account (HRA). The Health Reimbursement Account reimburses certain eligible Employees or Former Employees, on a before-tax basis, for certain out-of-pocket health care expenses not covered by a health care plan.

Health Savings Account (HSA). A Health Savings Account (HSA) is an account available to certain Eligible Employees who participate in a high-deductible health plan from which eligible health care expenses can be reimbursed with before-tax dollars.

Health Savings Account (HSA) Company Contributions. HSA Company Contributions are before-tax contributions made by the Company to an HSA that can be used to help pay for certain anticipated out-of-pocket health care expenses not covered by a health care plan.

Health Savings Account (HSA) Payroll Contributions. HSA Payroll Contributions are before-tax payroll contributions to an HSA that can be used to help pay for certain anticipated out-of-pocket health care expenses not covered by a health care plan.

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

Medicaid. Medicaid is the program providing health care benefits under Title XIX of the Social Security Act of 1965, as amended.

Medicare. 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.

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

Participant. An Employee who is making before-tax contributions through payroll deduction, or direct billing and payment, through the Plan. The term also includes a former Employee during the COBRA period or during the grace period for Claims reimbursement under the health care or dependent care flexible spending account sections of the Plan.

Participating Company. Participating Company means the Company and/or affiliate or business unit of the Company that has elected to participate in the Plan, 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 Flexible Spending Account Plan.

Plan Administrator. AT&T Services, Inc. is the Plan Administrator for the Plan.

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

PPACA. The PPACA refers to the Patient Protection and Affordable Care Act of 2010, as it may be amended from time to time. Any reference to any section of PPACA shall be deemed to include any applicable regulations and rulings.

Public Marketplace Exchange. Pursuant to the PPACA, A Public Marketplace Exchange is a marketplace for health insurance plans, made available by the government, either state or federal, or both. The health insurance plans on a Public Marketplace Exchange offer some core benefits – called essential health benefits – like preventive and wellness services, prescription drugs, and coverage for hospital stays.

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 health care coverage under the Plan in accordance with COBRA.

Regular Employee. A Regular Employee is an individual who is classified as a Regular Employee, whether full time or part time, by your employer that is a Participating Company in the Plan.

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

Special Enrollment Event. See the section titled "Special Enrollment for Employees and their Dependents Who Lose Eligibility for Medicaid or CHIP Coverage or Gain Eligibility for State Subsidies to Participate in the Plan" for further information.

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 individual 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 the Participating Companies and Applicable Collective Bargaining Agreements.

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

This table should not be used to determine if you personally are eligible to participate in the Plan. See the "Eligibility and Participation" section for more information on eligibility to participate in the Plan.

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
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)
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

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
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 - M	Alascom, Inc. AKI	Management	N/A
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
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

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
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
CINW - CWA District 3	AT&T Mobility Services LLC CINW	Bargained	AT&T Mobility Services LLC - CWA District 3 (Black Contract)
CINW - CWA District 3 - VI	AT&T Mobility Services LLC CINW	Bargained	AT&T Mobility Services LLC - CWA District 3 (Black Contract) - Virgin Islands
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, 2-13, 4, 7, 9	AT&T Mobility Services LLC CINW	Bargained	AT&T Mobility Services LLC - CWA Districts 1, 2-13, 4, 7, 9 (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
DTV_CSV - M	AT&T Customer Services, Inc. DTV_CSV	Management Employees added effective Aug. 6, 2017	N/A

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
DTV_CSV - IBEW Local 768 - CC	AT&T Customer Services, Inc. DTV_CSV	Bargained DTV Call Center Employees Effective Aug. 6, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Call Center Employees Agreement)
DTV_CSV - IBEW Local 291 - CC	AT&T Customer Services, Inc. DTV_CSV	Bargained DTV Call Center Employees Effective Aug. 6, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Call Center Employees Agreement)
DTV_CSV - CWA District 3	AT&T Customer Services, Inc. DTV_CSV	Bargained DTV Customer Assistants Effective Aug. 6, 2017	AT&T Mobility Services LLC - CWA District 3 (Black Contract)
DTV_CSV - CWA District 6	AT&T Customer Services, Inc. DTV_CSV	Bargained DTV Customer Assistants Effective Aug. 6, 2017	AT&T Mobility Services LLC - CWA District 6 (Purple Contract)
DTV_CSV - CWA Districts 1, 2-13, 4, 7, 9	AT&T Customer Services, Inc. DTV_CSV	Bargained DTV Customer Assistants Effective Aug. 6, 2017	AT&T Mobility Services LLC - CWA Districts 1, 2-13, 4, 7, 9 (Orange Contract)
DTV_ENT - M	DIRECTV Enterprises, LLC DTV_ENT	Management Effective Jan. 1, 2017	N/A
DTV - M	DIRECTV, LLC DTV	Management Effective Jan. 1, 2017	N/A
DTV - M OCCUP	DIRECTV, LLC DTV	Occupational Effective Jan. 1, 2017 Follows Management level of Benefits	N/A

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
DTV - CWA District 6	DIRECTV, LLC DTV	Bargained Effective June 1, 2017	AT&T Southwest Core Contract - CWA District 6
DTV - CWA District 4	DIRECTV, LLC DTV	Bargained Effective June 1, 2017	AT&T Midwest Core Contract - CWA District 4
DTV - CWA District 3	DIRECTV, LLC DTV	Bargained Effective June 1, 2017	AT&T Southeast Core Contract - CWA District 3
DTV - CWA	DIRECTV, LLC DTV	Bargained Effective June 1, 2017	AT&T Corp. Core Contract - CWA
DTV - CWA - NIC Tier 2	DIRECTV, LLC DTV	Bargained Effective June 1, 2017	AT&T Services, Inc., National Internet Contract - Tier 2 - CWA
DTV - IBEW Local 55	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 89	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 111	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 206	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 291	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 354	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
DTV - IBEW Local 426	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 449	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 714	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 769	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 827	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 949	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 1186	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 1250	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 1426	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
DTV - IBEW Local 1597	DIRECTV, LLC DTV	Bargained Effective Jan. 1, 2017	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
ILB - CWA District 4	Illinois Bell Telephone Company ILB	Bargained	AT&T Midwest Core Contract - CWA District 4

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
ILB - IBEW Local 21	Illinois Bell Telephone Company ILB	Bargained	IBEW System Council 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 Council 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 Council T-3 (AT&T Midwest Contract)
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

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
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
MJ - M	AT&T Digital Life, Inc. MJ	Management Management Employees transferring to this entity in December 2015.	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

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
PB - CWA District 9	Pacific Bell Telephone Company PB	Bargained	AT&T West Core Contract - CWA District 9
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
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

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
SBCSI - CWA District 6	AT&T Services, Inc. SBCSI	Bargained	AT&T Southwest Core Contract - CWA District 6
SBCSI - CWA District 9	AT&T Services, Inc. SBCSI	Bargained	AT&T West Core Contract - CWA District 9
SBCSI - M OCCUP	AT&T Services, Inc. SBCSI	DTV Occupational Effective Jan. 1, 2017 Follows Management level of Benefits	N/A
SBCSI - CWA District 3	AT&T Services, Inc. SBCSI	Bargained DTV Customer Assistants Effective June 1, 2017 through Aug. 6, 2017	AT&T Mobility Services LLC - CWA District 3 (Black Contract)
SBCSI - CWA District 6	AT&T Services, Inc. SBCSI	Bargained DTV Customer Assistants Effective June 1, 2017 through Aug. 6, 2017	AT&T Mobility Services LLC - CWA District 6 (Purple Contract)
SBCSI - CWA Districts 1, 2-13, 4, 7, 9	AT&T Services, Inc. SBCSI	Bargained DTV Customer Assistants Effective June 1, 2017 through Aug. 6, 2017	AT&T Mobility Services LLC - CWA Districts 1, 2-13, 4, 7, 9 (Orange Contract)
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 Council T-3 (AT&T Corp. National Contract)

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
SBCSI - IBEW Local 21 (Core)	AT&T Services, Inc. SBCSI	Bargained	IBEW System Council 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 Follows AT&T Midwest Core Contract - CWA District 4 level of Benefits.	N/A
SBCSI - NMNU MW IBEW	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Follows IBEW System Council T-3 (AT&T Midwest Contract) level of Benefits.	N/A
SBCSI - NMNU SW CWA	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Follows AT&T Southwest Core Contract - CWA District 6 level of Benefits.	N/A

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
SBCSI - NMNU West CWA	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Follows AT&T West Core Contract - CWA District 9 level of Benefits.	N/A
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
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 Follows 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	AT&T Corp. TCORP	Bargained	AT&T East Core Contract - CWA District 1
TCORP - CWA District 3	AT&T Corp. TCORP	Bargained	AT&T Southeast Core Contract - CWA District 3
TCORP - IBEW	AT&T Corp. TCORP	Bargained	IBEW System Council T-3 (AT&T Corp. National Contract)

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
TCORP - M	AT&T Corp. TCORP	Management	N/A
TCORP - NMNU CWA	AT&T Corp. TCORP	Nonmanagement Nonunion Hired before Aug. 8, 2009. Follows 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. Follows Legacy T Management level of Benefits.	N/A
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. Follows 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. Follows Legacy T Management level of Benefits.	N/A
TGSI - M	AT&T Government Solutions, Inc. TGSI	Management	N/A

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
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 Council T-3 (AT&T Corp. National Contract)
TSC - M	AT&T Support Services Company Inc. TSC	Management	N/A
TSRVC - CWA	Teleport Communications America, LLC TSRVC	Bargained	AT&T Corp. Core Contract - CWA
TSRVC - IBEW	Teleport Communications America, LLC TSRVC	Bargained	IBEW System Council 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. Follows AT&T Corp. Core Contract - CWA (Legacy T) level of Benefits.	N/A

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
TSRVC - NMNU M	Teleport Communications America, LLC TSRVC	Nonmanagement Nonunion Hired on or after Aug. 8, 2009. Follows Legacy T Management level of Benefits.	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. Follows 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. Follows Legacy T Management level of Benefits.	N/A
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

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

APPENDIX B

Eligibility, Characterization of Employees Eligible to Enroll, Eligibility Waiting Period, and Contribution Limits Matrix

Eligible Employee Group	Characterization of Employees Eligible to Enroll	Eligibility Waiting Period	Health Care FSA Contribution Limits	Dependent Care FSA Contribution Limits
Management Employees (including Management Expatriate Employees)	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Full-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
Nonmanagement Nonunion Employees (NMNUs) with Management Level Benefits include: AIS-CWA District 9 (CA/NV) AIS-NMNU Southeast Region NMNU TCORP NMNU DIRECTV - NMNU	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Full-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
AIS-CPE-CWA District 4	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
AIS-COS-CWA District 4	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
AIS-CWA	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000

Eligible Employee Group	Characterization of Employees Eligible to Enroll	Eligibility Waiting Period	Health Care FSA Contribution Limits	Dependent Care FSA Contribution Limits
AIS-IBEW Local 21	Regular Full-Time Regular Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
AIS-IBEW Local 58	Regular Full-Time Regular Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
AIS-IBEW Local 134	Regular Full-Time Regular Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
AIS-IBEW Local 494	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
Mobility - CWA CINW-CWA District 1, 2-13, 4, 7, 9 CINW-CWA District 3 CINW-CWA District 6 SBCSI-CWA District 3 SBCSI-CWA District 6 SBCSI-CWA Districts 1, 2-13, 4, 7, 9	Regular Full-Time Regular Part-Time	First of the month following completion of one month NCS	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
CINW-IBEW Local 1547	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
BLS Represented – Which includes: SBC-Ops-CWA District 3 SBCSI-CWA District 3 BCS-CWA District 3 BST-CWA District 3 (except as noted under BLS Special Represented) DTV – CWA District 3	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
BLS Special Represented – Which includes: BST(UO)-CWA District 3	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,600	Not Eligible

Eligible Employee Group	Characterization of Employees Eligible to Enroll	Eligibility Waiting Period	Health Care FSA Contribution Limits	Dependent Care FSA Contribution Limits
East Region Core-CWA District 1	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
TCORP-CWA **DTV-TCORP-CWA**	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
TCORP-IBEW	Regular Full-Time Regular Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
Midwest Region Core-CWA District 4 **DTV-CWA District 4**	Regular Full-Time Regular Part-Time Regular Limited Term Full-Time Regular Limited Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
Midwest Region Core-IBEW	Regular Full-Time Regular Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
DIRECTV Midwest – IBEW **DTV-IBEW Local 55** **DTV-IBEW Local 89** **DTV-IBEW Local 111** **DTV-IBEW Local 206** **DTV-IBEW Local 291** **DTV-IBEW Local 354** **DTV-IBEW Local 426** **DTV-IBEW Local 449** **DTV-IBEW Local 714** **DTV-IBEW Local 769** **DTV-IBEW Local 827** **DTV-IBEW Local 949** **DTV-IBEW Local 1186** **DTV-IBEW Local 1250** **DTV-IBEW Local 1426** **DTV-IBEW Local 1597** **SBCSI - IBEW Local 768 – CC** **SBCSI - IBEW Local 291 – CC**	Regular Full-Time Regular Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000

Eligible Employee Group	Characterization of Employees Eligible to Enroll	Eligibility Waiting Period	Health Care FSA Contribution Limits	Dependent Care FSA Contribution Limits
NIC Tier 1 **SBCIS Tier 1 CWA** **DTV-CWA-NIC Tier 2**	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
PB-IBEW Local 1269	Regular Full-Time Regular Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
SBCIST-NIC **SBCIST-NIC**	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
Southwest Region Core-CWA District 6 **DTV-CWA District 6**	Regular Full-Time Regular Part-Time Temp Full-Time Temp Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000
West Region Core-CWA District 9	Regular Full-Time Regular Part-Time Term Full-Time Term Part-Time	None	Minimum = $100 Maximum = $2,600	Minimum = $100 Maximum = $5,000

APPENDIX C

Qualified Status Changes Matrix

This matrix indicates whether you may make changes to your Before-Tax Premium Option (BTPO), Health Care Flexible Spending Account (Health Care FSA) and Dependent Care Flexible Spending Account (Dependent Care FSA) coverage elections during a Plan Year (Jan. 1 to Dec. 31) as a result of a Qualified Status Change under the AT&T Flexible Spending Account Plan. In all cases where this chart indicates that you may change your elections listed above, the election change must be on account of and consistent with the Qualified Status Change event. The Plan Administrator has discretion to determine whether an election change is on account of and consistent with a Qualified Status Change event.

This matrix does **not** apply to your ability to change your coverage election for benefits under the medical, dental, vision, CarePlus, Medical Plus or AD&D plans in which you may be participating. You should refer to the applicable SPD for such plans to determine your ability to make changes to those elections. Also, this matrix does not apply to changes to your Before-Tax HSA Payroll Deductions, which you may change at any time for any reason, as allowed by your HSA custodian or trustee.

Note: Refer to the bottom of the table for definitions of the codes used in the matrix.

<table>
<tr><th rowspan="2">Life Event</th><th colspan="5">Before-Tax Premium Option
(Paying Monthly Contributions on Before-Tax Dollars)</th><th rowspan="2">Health Care Flexible Spending Account (Health Care FSA)</th><th rowspan="2">Dependent Care Flexible Spending Account
(Dependent Care FSA)</th></tr>
<tr><th>Medical</th><th>Dental</th><th>Vision</th><th>CarePlus</th><th>AD&D</th></tr>
<tr><td rowspan="2">Marriage</td><td>AD, AS, C, DD, E, W</td><td>AD, AS, DD, E, W</td><td>AD, AS, DD, E, W</td><td>AD, AS, DD, E, W</td><td>AD, AS, DD, C, E, W</td><td>D, E, I</td><td>D, E, I</td></tr>
<tr><td colspan="5">Notes:
E, AD, AS – for newly eligible spouse and any dependent children of Employee or new spouse
DD, W – only if coverage is available under new spouse's plan</td><td>Notes:
E, I – for spouse and spouse's dependents
D – if new spouse has Health Care FSA</td><td>Notes:
E, I – for spouse's dependents
D – if new spouse is not employed or has Dependent Care FSA election with spouse's employer</td></tr>
</table>

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Death of spouse, divorce, legal separation, or legal annulment	AD, C, DD, DS, E	AD, DD, DS, E	AD, DD, DS, E	AD, DD, DS, E	AD, DD, DS, C, E, W	D, E, I	D, E, I
	Notes: E, AD – if lose coverage under spouse's plan DS DD – only if dependents have coverage under spouse's plan					**Notes:** E, I – if lose Health Care FSA under spouse's plan	**Notes:** E, I – to accommodate newly eligible dependents D – if dependent no longer eligible
Gain of dependent status, birth, adoption, placement for adoption	AD, AS, C, E, W	AD, AS, E, W	AD, AS, E, W	AD, AS, E, W	AD, AS, DD, DS, C, E, W	D, E, I	E, I
	Notes: E, AD, AS – for newly Eligible Dependent child or any other dependent child W – only if coverage is available under spouse's plan					**Notes:** D – if spouse has Health Care FSA	**Notes:** E, I – to accommodate newly eligible dependents D – if loss of eligibility due to spouse no longer working
Loss of dependent eligibility status	DD	DD	DD	DD	AD, AS, DD, DS, C, E, W	D	D
	Notes: DD – may only drop dependent who lost eligibility						
QMCSO requiring an Employee to cover a dependent or alternate payee	AD, C	AD	AD	AD	DNA	E, I	N

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
QMCSO requiring former spouse to cover a dependent or alternate payee under the spouse's coverage	DD	DD	DD	DD	DNA	D	N
Expiration of QMCSO	W, DD, C	W, DD	W, DD	W, DD	DNA	W	W
Death of covered dependent	DD	DD	DD	DD	AD, AS, DD, DS, C, E, W	D	D
	Notes: DD – may only drop deceased dependent						
Gain of employment and benefit coverage by spouse or dependent	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	D	D, E, I
	Notes: DD, DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer's plan					**Notes:** D – if spouse has Health Care FSA	**Notes:** E, I – if newly eligible due to spouse's employment D – if dependent added under spouse's Dependent Care FSA

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Loss of employment and benefit coverage by spouse or dependent	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E, I	D, E, I
	Notes: AD, AS, E – only with respect to Employee, spouse, or dependent who lost coverage under another employer's plan						**Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA D – if loss of eligibility due to spouse no longer working
Dependent gains coverage under another employer's plan	DD	DD	DD	DD	AD, AS, DD, DS, C, E, W	D	D, E, I
							Notes: E, I – if newly eligible due to dependent's parents' employment D – if dependent added under spouse's Dependent Care FSA

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Dependent loses coverage under another employer's plan	AD, C, E	AD, E	AD, E	AD, E	AD, AS, DD, DS, C, E, W	E, I	D, E, I
	Notes: AD, E – only with respect to dependent who lost coverage under another employer's plan						**Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA D – if loss of eligibility due to spouse no longer working
Relocation triggering gain of plan benefit/ option eligibility	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	N	D, E, I
	Notes: AD, AS, E – only if eligibility for coverage option is gained						**Notes:** D, E, I – only if dependent care provider changes and charges a different rate
Relocation triggering loss of plan benefit/ option availability or eligibility	C, W	W	W	W	AD, AS, DD, DS, C, E, W	N	D, E, I
	Notes: W – only if eligibility for coverage option is lost						**Notes:** D, E, I – only if dependent care provider changes and charges a different rate

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Change in Employee's work schedule or employment status resulting in gain of benefit plan coverage	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E	E
	Notes: AD, AS, E – only if eligibility for coverage option is gained					**Notes:** E – only if eligibility for Health Care FSA is gained	**Notes:** E – only if eligibility for Dependent Care FSA is gained
Change in Employee's work schedule or employment status resulting in loss of Employee benefit plan coverage	C, DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	D	D
	Notes: DD, DS, W – only with respect to Employee, spouse, and/or dependent who loses eligibility					**Notes:** D – only if eligibility for Health Care FSA is lost	**Notes:** D – only if eligibility for Dependent Care FSA is lost
Change in spouse's or dependent's work schedule or employment status resulting in loss of eligibility under spouse's or dependent's employer's benefit plan	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E, I	D, E, I
	Notes: AD, AS, E – only with respect to Employee, spouse, or dependent who lost coverage under another employer's plan						**Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA D – if loss of eligibility due to spouse no longer satisfying working requirements

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Change in spouse's or dependent's work schedule or employment status resulting in gain of eligibility under spouse's or dependent's employer's benefit plan	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	D	N
	Notes: DD, DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer's plan					**Notes:** D – if spouse has Health Care FSA	
Mid-year expiration of COBRA coverage from another employer (Employee, spouse, or dependent)	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	DNA	E, I	N
Decrease in coverage or cost increase under spouse's or dependent's employer's benefit plan(s)	AD, AS, C*, E *Per HIPAA, only if company contributions cease	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	N	E, I
	Notes: AD, AS, E – if Employee, spouse, and/or dependent coverage under other employer's plan is decreased or dropped						**Notes:** E, I – if coverage under other employer's Dependent Care FSA is eliminated or decreased

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	**Dental**	**Vision**	**CarePlus**	**AD&D**		
Increase in coverage or cost decrease under spouse's or dependent's employer's benefit plan(s)	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	N	D
	Notes: DD, DS, W – if Employee, spouse, and/or dependent coverage under other employer's plan is added						**Notes:** D – if coverage under other employer's Dependent Care FSA is elected
Significant increase in cost of Employee's benefit package option	AD, AS, C*, DD, DS, E, W *Per HIPAA, only if Company contributions cease	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, C, E, W	N	N
	Notes: May increase election to match cost increase, OR W with AD, AS, E - under another benefit package option providing similar coverage, OR W, DD, DS - If no other benefit package providing similar coverage						

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Significant decrease in cost of Employee's benefit package option	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, C, E, W	N	N
	Notes: May decrease election to match cost decrease, OR W, DD, DS with AD, AS, E – drop other benefit package option and add benefit package option with decreased cost						
A change in dependent care cost or coverage including changing day care provider (non-related)	DNA	DNA	DNA	DNA	DNA	N	D, E, I
Employee starts a leave of absence whether paid or unpaid, whether FMLA or non-FMLA	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	D	D
Employee returns from a leave of absence whether paid or unpaid, whether FMLA or non-FMLA	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E, I	E, I

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Spouse or dependent starts an unpaid leave of absence (or FMLA leave) with resulting loss in eligibility under spouse's or dependent's employer's benefit plan	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E, I	D, E, I
	Notes: AD, AS, E – only with respect to Employee, spouse, or dependent who lost coverage under another employer's plan						**Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA D – if loss of eligibility due to spouse no longer satisfying working requirements
Employee or spouse becomes disabled	N	N	N	N	AD, AS, C, DD, DS, E, W	N	D, E, I
							Notes: E, I – if coverage is lost under spouse's employer's Dependent Care FSA D – if loss of eligibility due to spouse no longer satisfying working requirements

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Spouse or dependent returns from an unpaid leave of absence with resulting gain in eligibility under spouse's or dependent's employer's benefit plan (or from FMLA leave)	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	E, I	E, I
	Notes: DD, DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer's plan						**Notes:** E, I – if newly eligible due to spouse satisfying working requirements D – to accommodate gain of coverage under spouse's employer's Dependent Care FSA
Spouse starts an unpaid leave of absence (non-FMLA) without change in eligibility	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	N	N
	Notes: AD, AS, E – only with respect to Employee, spouse, or dependent who loses coverage under another employer's plan						
Spouse or dependent returns from an unpaid leave of absence (non-FMLA) without change in eligibility	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	N	N
	Notes: DD, DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer's plan						

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Addition or significant improvement of benefit option to Employee's plan	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, C, E, W	N	D with E, I
	Notes: DD, DS, W with AD, AS, E – may drop current benefit option and elect significantly improved benefit option AD, AS, E – if not previously enrolled in a benefit option, may elect significantly improved benefit option						**Notes:** D with E, I – may drop current option and elect significantly improved benefit option
Addition of benefit option to spouse's or dependent's employer's benefit plans	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	N	D
	Notes: DD, DS, W – if Employee, spouse, and/or dependent coverage under other employer's plan is added						**Notes:** D – if coverage under other employer's Dependent Care FSA is elected
Employee entitlement to Medicare/ Medicaid coverage	C, W	C, W only if Medicaid provided Dental Coverage	C, W only if Medicaid provided Vision Coverage	C, W	N	D	N
	Notes: W – if Employee adds Medicaid coverage						

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Employee loss of Medicare/Medicaid coverage	AD, AS, C, E	AD, AS, C, E only if Medicaid provided Dental Coverage	AD, AS, C, E only if Medicaid provided Vision Coverage		N	E, I	N
	Notes: AD, AS, E – if dependent or spouse loses Medicaid coverage						
Spouse/ dependent entitlement to Medicare/ Medicaid coverage	DD, DS	DD, DS only if Medicaid provided Dental Coverage	DD, DS only if Medicaid provided Vision Coverage	DD, DS	N	D	N
	Notes: DD, DS – if dependent or spouse adds Medicaid coverage						
Spouse/ dependent loss of Medicare/ Medicaid coverage	C, E, AD, AS	AD, AS, E only if Medicaid provided Dental Coverage	AD, AS, E only if Medicaid provided Vision Coverage		N	E, I	N
	Notes: AD, AS, E – if dependent or spouse loses Medicaid coverage						

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Employee commences strike or lockout resulting in a change in benefit eligibility	W	W	W	W	AD, AS, DD, DS, C, E, W	D	D
Employee returns from strike or lockout resulting in a change in benefit eligibility	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E	E, I
Spouse or dependent commences strike or lockout	AD, AS, C*, E *Per HIPAA, only if there is a loss in coverage	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E, I	D
Spouse or dependent returns from strike or lockout	C*, DD, DS, W *Per HIPAA, only if there is a loss in coverage	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	D	E, I

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Significant curtailment or termination of Employee's coverage with or without a loss of coverage	C, DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	N	D, E, I
Significant curtailment or termination of spouse's or dependent's coverage under spouse's or dependent's employer's benefit plan(s) with a loss of coverage when no similar coverage is available	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	N	E, I
Employee rehires within 30 days of termination	Reinstate prior election; no changes allowed.	Reinstate prior election; no changes allowed.	Reinstate prior election; no changes allowed.	Reinstate prior election; no changes allowed.	Reinstate prior election; no changes allowed.	Reinstate prior election; no changes allowed.	Reinstate prior election; no changes allowed.
Employee rehires after 30 days following termination	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, E	E	E

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	**Dental**	**Vision**	**CarePlus**	**AD&D**		
Non-AT&T spouse's or dependent's annual enrollment does not correspond with Employee's annual enrollment	AD, AS, C*, DD, DS, E, W *Per HIPAA, only if there is a loss in coverage	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W	AD, AS, DD, DS, C, E, W	N	D, E, I
	Notes: AD, AS, DD, DS, E, W – changes permitted to reflect corresponding changes in non-AT&T spouse's plan						**Notes:** D, E, I - changes permitted to reflect corresponding changes in non-AT&T spouse's Dependent Care FSA Plan
Employee gains eligibility under another employer's group plan(s)	DD, DS, W	DD, DS, W	DD, DS, W	DD, DS, W	AD, AS, DD, DS, C, E, W	N	D
	Notes: DD, DS, W – if Employee, spouse, and/or dependent coverage under other employer's plan is added						**Notes:** D – if coverage under other employer's Dependent Care FSA is elected

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Employee loses eligibility under another employer's group plan(s)	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	AD, AS, DD, DS, C, E, W	E	E, I
Employee loss of other government or educational institution coverage such as tribal coverage, state health benefits risk pool, or foreign government plan	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	DNA	N	N
Spouse or dependent loss of other government or educational institution coverage such as tribal coverage, state health benefits risk pool, or foreign government plan	AD, AS, C, E	AD, AS, E	AD, AS, E	AD, AS, E	DNA	N	N
Employee, spouse or dependent meets or exceeds lifetime limit	C, W	N	N	N	DNA	N	N

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Employee, spouse or dependent complete loss of employer subsidy from another employer	C, E, AD, AS	N	N	N	DNA	N	N
Employee gains eligibility in Public Marketplace Exchange due to reduction in expected hours of service from more than 30 hours per week to less than 30 hours per week	W	N	N	W	DNA	N	N
	Notes: W – only if employee enrolls self and individuals losing coverage in minimum essential coverage under another plan by the first day of the second month following the month in which coverage is revoked.						

Life Event	Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars)					Health Care Flexible Spending Account (Health Care FSA)	Dependent Care Flexible Spending Account (Dependent Care FSA)
	Medical	Dental	Vision	CarePlus	AD&D		
Employee gains eligibility in Public Marketplace Exchange due to Special or Annual Enrollment period	W	N	N	W	DNA	N	N
	Notes: W – only if employee enrolls self and individuals losing coverage in Public Marketplace Exchange effective no later than the day immediately following the last day of the prior coverage that was revoked.						

The following is an explanation of the change codes used in this matrix.

AD = Add Dependent(s)

AS = Add Spouse

C = Change in coverage options

D = Decrease/Drop

DD = Drop Dependent(s)

DNA = Does Not Apply

DS = Drop Spouse

E = Enroll

I = Increase

N = No change

W = Waive/drop election