

2010 Benefits Preview



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IMPORTANT

This document was written to make it easier to read. So, sometimes it uses informal language, like “AT&T employees,” instead of precise legal terms. Also, this is only a summary, and your particular situation could be handled differently. More specific details about your benefits, including eligibility rules, are in the summary plan descriptions (SPDs), summaries of material modifications (SMMs) or the plan documents. Except for the changes described in this document, the plan documents always govern, and they are the final authority on the terms of your benefits. AT&T reserves the right to terminate or amend any and all benefits plans, and your participation in the plan is neither a contract nor a guarantee of future employment.

Your years of service to AT&T are highly valued, and we are pleased to be able to continue to provide you with some of the best retiree health care coverage in America — health care that is heavily subsidized by the company at a level far greater than that offered by the vast majority of other companies.

In this communication, you’ll find more information about your 2010 company-sponsored medical options. Next year, in addition to your existing medical option, we will be offering a new coverage choice called the Alternative Medical Option, giving you greater flexibility in selecting the coverage you need to meet your individual needs.

Please review the information in this communication carefully before selecting a coverage option during your upcoming annual enrollment period.

Information about HMOs, if any are available to you, will be shared before your upcoming enrollment period.

AUDIENCE

This document serves as an SMM for retired bargained employees of legacy BellSouth who retired on or after Jan. 1, 1992; retired nonmanagement nonunion employees of LM Berry who retired on and after June 1, 2008; and any associated LTD recipients, survivors of retired employees and COBRA participants, excluding BellSouth Internet Services and National Directory and Customer Assistants. These changes do not apply to any other participants in the plan.

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PLEASE KEEP THIS BOOKLET FOR FUTURE REFERENCE.

This booklet, as it pertains to medical and prescription drug benefits, serves as a summary of material modifications (SMM) to the BellSouth Retiree Medical Assistance Plan summary plan description (SPD) dated April 2006. For all other changes to benefits included in this booklet, further information will be provided in a future SPD or SMM. (See affected audience at left.)

Changes to Your Existing Medical Option

If You or Your Eligible Family Members Are Eligible for Medicare

Those of you who are Medicare-eligible will be able to participate in your current Existing Regional Medical Option in 2010, and no monthly contributions will be required to participate. (See "Important Information About Contributions" below right.)

Generally speaking, your current plan benefits will remain the same in 2010 with the exception of your prescription drug program. However, you may see a few changes resulting from changes in the law and existing plan provisions. Also, preventive care benefits will be paid at 100 percent of eligible expenses for network services for all participants. Any changes will be reflected in your health plan comparison chart.

Your prescription drug program is changing. Beginning on page 10, you will find an overview of your prescription drug program.

If You or Your Eligible Family Members Are Not Eligible for Medicare

Those of you who are not eligible for Medicare will be able to participate in your current Existing Regional Medical Option in 2010.

Generally speaking, your current plan benefits will remain the same in 2010 with the exception of your prescription drug program. However, you may see a few changes resulting from changes in the law and existing plan provisions. Also, preventive care benefits will be paid at 100 percent of eligible expenses for network services for all participants. Any changes will be reflected in your health plan comparison chart. The following monthly contributions will be required to participate:

2010 MONTHLY CONTRIBUTIONS FOR YOUR EXISTING REGIONAL MEDICAL OPTION

| | |
|------------------------------------------|---------|
| Individual | \$13.46 |
| Individual + 1 Dependent | \$24.86 |
| Individual + 2 or More Dependents | \$34.36 |

See "Important Information About Contributions" at right.

Your prescription drug program is changing. Beginning on page 10, you will find an overview of your prescription drug program.

FREQUENTLY ASKED QUESTION

Next year, can I participate in the same company-offered medical option I participate in now?

Generally, yes. The company-offered medical option now available to you will be available in 2010, provided you pay any applicable monthly contributions and continue to be eligible for that option. You also will have the ability to choose coverage through a new choice called the Alternative Medical Option (see page 2). In certain locations, an HMO-type option may also be available, but it is subject to change from year to year.

IMPORTANT INFORMATION ABOUT CONTRIBUTIONS

If you are a survivor of a retired employee, on COBRA or retired as a part-time employee, your contributions may differ. For your contribution amounts, see the health plan comparison chart that will be provided during your enrollment period.

◀ The defined dollar benefit (DDB) cap, which had been waived in the past, is being implemented beginning Jan. 1, 2010. The DDB cap has been raised from \$9,000 to \$12,500 and will be calculated based on costs for all similarly situated non-Medicare-eligible retired bargained employees of the company.



PRESCRIPTION DRUGS ARE A SEPARATE BENEFIT

Your prescription drug benefit is offered separately from your medical and MH/CD benefits. An overview of your prescription drug changes for 2010 starts on page 10.

FREQUENTLY ASKED QUESTION

How is the Alternative Medical Option different from my current company option?

Simply put, the Alternative Medical Option is a different version of the same company-sponsored medical plan you are eligible to participate in today, but it has different deductibles, coinsurance and out-of-pocket maximums.

IMPORTANT

In 2010, ValueOptions will become your claims administrator for mental health/chemical dependency (MH/CD) services. More information about your MH/CD benefits will be shared before annual enrollment.

Medicare Split Family

Split family is a benefits term used to describe a family that includes members who are eligible for Medicare and others who are not. If you and your eligible dependents are considered a split family, and if your plan includes an annual deductible and an annual out-of-pocket maximum, expenses that count toward meeting these amounts will no longer accumulate together when you enroll in your Existing Regional Medicare and Non-Medicare Medical Options. Instead, you will be subject to separate deductibles and out-of-pocket maximums.

Example: If you are Medicare-eligible and your dependents are not, then you will have an annual deductible and an annual out-of-pocket maximum to meet and your non-Medicare dependents will have a separate annual deductible and a separate annual out-of-pocket maximum to meet. Your expenses will count only toward meeting your annual deductible and out-of-pocket maximum.

New! The Alternative Medical Option

In 2010, eligible bargained retirees will have an opportunity to participate in a new medical coverage choice called the Alternative Medical Option. Both the Alternative Medical Option and your Existing Regional Medical Option provide coverage for the same services; however, they feature different monthly contribution levels, annual deductibles, copayments/coinsurance and out-of-pocket maximums.

On the following pages, we'll be taking a closer look at how the Alternative Medical Option works. Information about the other options you may be eligible to participate in next year, such as HMOs, will be shared during annual enrollment. In the following sections, the information pertains specifically to the Alternative Medical Option, except where noted.

How the Alternative Medical Option Works

The Alternative Medical Option is similar to your Existing Regional Medical Option in many ways but differs in others. For one, there are no monthly contributions for the Alternate Medical Option. (See “Important Information About Contributions” below right.)

Here’s a high-level look at how the new option works when you use network providers for medical services, including mental health/chemical dependency (MH/CD).

- 1 For preventive medical services (see next section for more on this), the Alternative Medical Option pays 100 percent as long as you use network providers. The plan even picks up the cost of the office visit for preventive care.
- 2 For nonpreventive services, you pay 100 percent of the cost until you meet your applicable annual deductible.
- 3 Once you meet your annual network deductible, you pay for 10 percent* of your eligible network expenses.
- 4 You continue paying 10 percent* of your eligible medical and MH/CD expenses until you reach your applicable annual out-of-pocket maximum. After that, benefits are payable at 100 percent of your eligible network expenses for the rest of the year; however, all other plan terms and conditions continue to apply.

*You are responsible for paying 50 percent of your eligible expenses if you have met your non-network deductible and use a non-network provider until you reach your non-network out-of-pocket maximum. All other plan terms and conditions will apply. Your out-of-pocket expenses may be significant when using non-network providers.

FREQUENTLY ASKED QUESTION

Why would someone elect to participate in the Alternative Medical Option?

If you and your dependents are light users of medical services, the Alternative Medical Option may make better financial sense for you. To help you weigh your options, an online Medical Expense Estimator will be available through the AT&T Benefits Center Web site during your annual enrollment period. The estimator will have all of your medical options listed and allow you to estimate the level of out-of-pocket expense you could incur through each of your available options. You are encouraged to review your options carefully before making an enrollment election.

IMPORTANT INFORMATION ABOUT CONTRIBUTIONS

If you are a survivor of a retired employee, on COBRA or retired as a part-time employee, your contributions may differ. For your contribution amounts, see the health plan comparison chart that will be provided during your enrollment period.



NO-COST SERVICES CAN HAVE A BIG PAYOFF

It's been said that without your health you have nothing. Some plan participants delay or don't seek out the health care services that are available to them at no cost. Our thought on the topic? Don't wait! Preventive care services can help detect small problems before they become big ones. Schedule some time early in the year with your network provider to get an annual physical and determine which services make the most sense for you. Remember, no-cost preventive services are available only from network providers.

Preventive and Nonpreventive Services

What's the difference? In short, as a participant in the Alternative Medical Option, you don't pay for services that are considered preventive when you use network providers, but you generally do pay for nonpreventive services. Preventive care services are generally linked to routine wellness exams, while nonpreventive services are considered treatment or diagnosis for an existing illness, injury or condition.

Eligible preventive care services are covered at 100 percent by the plan as long as you use network providers; otherwise, you may have limited coverage or no coverage at all. Contact your claims administrator for more information.

There may be limits on how often you can receive preventive care treatments and services. And depending on the situation, services might be considered preventive or nonpreventive. Your claims administrator's guidelines determine which services are considered preventive care and may change over time. Always consult with your health care provider to clarify the type of service you're receiving. Remember, preventive care services are generally linked to routine wellness exams only.

Examples of preventive care:

- > Annual routine physicals
- > Some immunizations
- > Pap smears
- > Mammograms
- > Cholesterol screenings
- > Colonoscopies

This isn't a comprehensive list. For more information on what services qualify as preventive care, contact your medical claims administrator (see page 17).

Note: Like your Existing Regional Medical Option, the Alternative Medical Option may include limits on such services as outpatient therapy, physical therapy and skilled nursing. Contact your medical claims administrator for more information.

Participation Costs

Now that you've seen how the Alternative Medical Option works, let's look at the three key aspects — contributions, annual deductibles and out-of-pocket maximums.

Note: *You have separate deductibles and out-of-pocket maximums for prescription drugs. Your prescription drug annual costs are explained in the Changes to Your Prescription Drug Program section on page 10.*

Contributions

There are no monthly contributions associated with the Alternative Medical Option for you and your eligible dependents.

IMPORTANT: If you are a survivor of a retired employee, on COBRA or retired as a part-time employee, your contributions may differ. For your contribution amounts, see the health plan comparison chart that will be provided before your enrollment period.

Annual Deductible for Medical and MH/CD Services

Simply put, your medical annual deductible is the amount of money you must first pay out of pocket for eligible nonpreventive expenses before the Alternative Medical Option starts picking up a portion of these costs. *You are responsible for paying 100 percent of the cost of nonpreventive services — those considered treatment or diagnosis for an existing illness, injury or condition — until you meet your applicable annual deductible.*

There are two different annual deductibles and out-of-pocket maximum amounts. One set applies when you seek care from network providers. A separate set applies if you are assigned (or opt into) network status and you use non-network providers. After you meet your network deductible, 90 percent of eligible network expenses are covered. You pay the remaining 10 percent (coinsurance) until you reach your network out-of-pocket maximum for medical and mental health/chemical dependency (MH/CD) services.

QUICK QUIZ: PREVENTIVE OR NOT?

When you visit a health care provider, the services you receive will be considered either preventive or nonpreventive. See if you can determine in the scenarios below whether the care described would be considered preventive or nonpreventive.

SITUATION 1

A woman visits her doctor for her annual mammogram.

Answer: This is considered preventive care because her visit is part of a routine annual exam and has not been prompted by a previous diagnosis.

SITUATION 2

A woman goes to the doctor for a mammogram and is asked to return for another one because of questionable results from the first test.

Answer: The first visit is considered preventive. The follow-up visit is not. The second mammogram and any additional tests would be considered treatment for an existing condition.

After you meet your non-network deductible, 50 percent of eligible non-network expenses are covered. You pay the remaining 50 percent (coinsurance) until you reach your non-network out-of-pocket maximum for medical and MH/CD services.

NETWORK – 2010 ANNUAL DEDUCTIBLES

| | |
|----------------------------|-------|
| Individual Coverage | \$400 |
| Family Coverage | \$800 |

NON-NETWORK – 2010 ANNUAL DEDUCTIBLES

| | |
|----------------------------|---------|
| Individual Coverage | \$1,200 |
| Family Coverage | \$2,400 |

All eligible medical and MH/CD expenses related to nonpreventive care that you incur apply to your annual deductible. With family coverage, a covered person is eligible to receive benefits once his or her eligible expenses satisfy the individual deductible amount. The family deductible is met once a combination of covered participants' eligible expenses meets the family deductible amount. Although it is not necessary that any one person reach his or her individual deductible amount, no one person may contribute more than the individual deductible amount toward meeting the family deductible.

Your network charges will apply only to your network deductible, and your non-network charges will apply only to your non-network deductible.

Out-of-Pocket Maximum for Medical and MH/CD Services

Your out-of-pocket maximum is the most money you can pay after you meet your deductible for eligible medical and MH/CD network services annually before the plan begins paying for 100 percent of your eligible expenses with network providers. However, the amounts you pay for your annual deductible do not count toward your out-of-pocket maximum, but your coinsurance payments count toward meeting your network annual out-of-pocket maximum.

2010 OUT-OF-POCKET MAXIMUMS

| | Network | Non-Network |
|---------------------------|----------------|--------------------|
| Individual Maximum | \$1,000 | \$3,000 |
| Family Maximum | \$3,000 | \$9,000 |

All coinsurance amounts you pay for eligible medical and MH/CD expenses related to nonpreventive care that you incur apply to your out-of-pocket maximum. With family coverage, the plan begins to pay for 100 percent of eligible expenses for a covered individual once that person's eligible expenses satisfy the individual out-of-pocket maximum amount. The family out-of-pocket maximum is met once a combination of covered participants' eligible expenses meets the family out-of-pocket maximum amount. Although it is not necessary that any one person reach their individual out-of-pocket maximum amount, no one person may contribute more than the individual out-of-pocket maximum amount toward meeting the family out-of-pocket maximum.

Your network charges will apply only to your network out-of-pocket maximum, and your non-network charges will apply only to your non-network out-of-pocket maximum.

Medicare Split Family

If you and your eligible dependents are considered a split family, your eligible medical and MH/CD expenses will accumulate together toward meeting your annual deductible and out-of-pocket maximum when you all enroll in the Alternative Medical Option. If some of you enroll in your Existing Regional Medical Option and some enroll in the Alternative Medical Option, then separate deductibles and out-of-pocket maximums will apply for those enrolled in each option.

Determining Whether Your Provider Is in the Network

Contact your claims administrator or visit its Web site to determine whether your provider is in your administrator's network. Your network providers might switch to non-network providers midyear or vice versa. So check that your provider is in the network before you enroll in an option or receive service.

The Participant Experience — Receiving Care

Follow these simple steps to receive care:

- 1** Present your medical ID card — which you'll typically receive in late December or early January — to your medical provider before receiving service, and ask your provider to file your claim.
- 2** After you receive service, your provider will file a claim with your administrator.
- 3** Your administrator will notify your provider how much of the claim it will pay. Your provider will then send you a bill for the amount you may owe.

Things you should know about paying for service with the Alternative Medical Option:

- > Generally, you shouldn't pay anything at the time you receive service.
- > The medical coding your provider uses generally determines whether services are preventive or nonpreventive. To be safe, ask your provider for clarification before you receive service.
- > The money you've paid toward your annual deductible for nonpreventive services will be tracked by your claims administrator.

QUICK QUIZ: PREVENTIVE OR NOT?

SITUATION 3

A man who takes medicine for high cholesterol has an annual wellness exam and receives a blood test to measure his cholesterol level.

Answer: Although the man is taking cholesterol medicine, the office visit and the blood test are considered preventive care because they are part of his overall wellness exam.

SITUATION 4

A man makes quarterly visits to the doctor for blood tests to check his cholesterol level and to confirm the dosage level is appropriate.

Answer: The quarterly blood tests he receives are considered nonpreventive because they are considered treatment for an existing condition.



FREQUENTLY ASKED QUESTION

If I or one of my dependents has a pre-existing condition, will this affect my ability to enroll in the Alternative Medical Option?

No. There are no exclusions for pre-existing conditions for enrolling in the Alternative Medical Option.

The Alternative Medical Option in Action

Now let's take a look at a couple of examples of the plan in action. Clearly, these examples are not comprehensive nor meant to cover every situation, but they give you a good sense of how the plan works and how costs are paid. The dollar amounts used in these examples are estimates based on industry averages.

Example 1

Richard is a 55-year-old retiree who is enrolled in individual coverage under the Alternative Medical Option. He uses network providers for his care and is not eligible for Medicare. Under this new option, Richard's annual deductible is \$400. Here's an example of Richard's medical care for the year and how the costs are paid.

Early in the year, Richard has his annual physical and cholesterol screening, and his doctor recommends he have a routine colonoscopy. Later in the year, Richard cuts his hand, which requires stitches.

RICHARD'S COSTS

| | Plan Pays | Richard Pays |
|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Annual Contributions | | |
| No contributions are required to participate | | \$0 |
| Preventive Care | | |
| > Routine annual physical and cholesterol screening (\$165) | The plan pays 100 percent of eligible network preventive care. \$165 | \$0 |
| > Routine colonoscopy, which was recommended as part of Richard's annual physical (\$1,315) | The plan pays 100 percent of eligible network preventive care. \$1,315 | \$0 |
| Nonpreventive Care | | |
| > Cut to hand, including urgent care visit and minor outpatient procedure (\$700) | \$270 | Richard pays his \$400 annual deductible, plus 10 percent of the \$300 difference. \$430 |
| > Follow-up appointment with specialist (\$150) | \$135 | Richard pays 10 percent of the cost. \$15 |
| Total: \$2,330 | \$1,885 | \$445 |

Example 2

John is a Medicare-eligible retiree who is enrolled in individual coverage under the Alternative Medical Option. Under this option, John's annual deductible is \$400. John also has a Medicare Part B deductible of \$135, which counts toward his annual deductible. After the Medicare Part B deductible is met, Medicare covers 80 percent of eligible expenses. In this example, let's assume that John's first nonpreventive visit of the year was caused by an accidental fall.

| JOHN'S COSTS | | | |
|-------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------|--------------------|
| | Medicare Pays | Plan Pays | John Pays |
| > Routine annual physical and cholesterol screening (\$165) | N/A | The plan pays 100 percent of eligible network preventive care. \$165 | \$0 |
| > Routine colonoscopy, which was recommended as part of John's annual physical (\$1,315) | N/A | The plan pays 100 percent of eligible network preventive care. \$1,315 | \$0 |
| > Treatment for a broken arm (\$1,500) and lower back pain (\$300) resulting from a fall ¹ | \$1,332 ² | \$0 ³ | \$468 ⁴ |

HOW THE CLAIM IS PAID

¹For illustrative purposes, this example uses a one-time charge related to John's accidental fall. It does not reflect any follow-up visits that may be necessary or related billings.

²Medicare pays 80 percent of the balance that remains after John meets his \$135 Medicare deductible.

³In this example, the Alternative Medical Option does not pay a portion of the claim. Here's why: The plan is responsible for paying 90 percent of the eligible charge after the deductible is met. In this example, that would be \$1,260 $(\$1,800 - \$400) \times 90 \text{ percent} = \$1,260$.

Because Medicare has paid an amount (\$1,332) that is larger than the Alternative Medical Option responsibility (\$1,260), the plan does not pay on this claim.

John is responsible for paying the remaining \$68 after he has met his \$400 individual deductible and Medicare pays \$1,332.

⁴John is responsible for paying the following expenses related to his accident:

- > \$135 — Medicare Part B deductible
- > \$265 — The difference between his medical plan deductible (\$400) and his Medicare Part B deductible (\$135)
- > \$68 — The balance remaining after Medicare has paid its portion of the claim.

Because John has now met his \$400 individual deductible, he will pay 10 percent of his network medical and MH/CD costs until he meets his \$1,000 annual out-of-pocket maximum.

FREQUENTLY ASKED QUESTION

If I enroll in the Alternative Medical Option, do I have to use network providers?

No. You can use any provider you choose; however, you may end up paying much more when you use non-network providers because the annual deductibles, coinsurance amounts and out-of-pocket maximums are significantly more expensive. Also, in most situations, the preventive care services offered through the Alternative Medical Option are covered at 100 percent only when you use network providers.



IMPORTANT

If you enroll in an HMO, you are not eligible for prescription drug coverage under the BellSouth Retiree Medical Assistance Plan. Contact your HMO for more information about the prescription drug coverage available to you under your HMO.

Your New Prescription Drug Program

Your prescription drug program will be the same whether you enroll in your Existing Regional Medical Option or in the Alternative Medical Option. You will pay an annual deductible toward prescription costs before the plan begins to pay. After your annual deductible is met, your out-of-pocket costs will be largely influenced by two factors: the types of drugs you purchase and where you buy them. In this section, we'll take a closer look at the program and discuss the special situations that apply to maintenance drugs, specialty prescription drugs and personal-choice drugs.

How the Prescription Drug Program Works

You are responsible for paying the full price of your prescription drugs until you meet your annual prescription drug deductible. You are then responsible for making a copayment for each prescription until you reach your annual prescription drug out-of-pocket maximum. If you take a maintenance medication, you must use the mail order prescription drug program (page 14) after the first two fills to receive any benefit.

Understanding the Types of Prescription Drugs

Here are the most common types of drugs available through the plan.

Generic Drugs

These have the same active ingredient as brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Generic drugs have the least expensive copayment.

The prescription drug claims administrator promotes the use of generic drug equivalents whenever possible. The prescription drug claims administrator may fill your prescription with a generic drug if the prescription is not marked "Dispense as Written." Even if the prescription contains this stipulation, a change to a generic drug equivalent may be made if the prescription drug claims administrator's pharmacist contacts your physician and obtains his or her consent, either written or verbal. If the physician does not approve the change, your prescription will be filled as originally written.

MORE INFO IS JUST A CLICK AWAY ▶

CVS Caremark is the administrator of your prescription drug program. To see which category your prescription drug belongs to, visit the Caremark Web site at www.caremark.com. See page 17 for more information.

Preferred Drugs

These are brand-name prescription drugs. These drugs appear on the prescription drug administrator's preferred list.

Nonpreferred Drugs

These are brand-name prescription drugs that do not appear on the preferred list. The copayment for nonpreferred drugs is higher than that of generic or preferred drugs. To see which category your prescription drug belongs to, visit the Caremark Web site.

Specialty Prescription Drugs

Specialty prescription drugs are used in the management of chronic diseases that require complex pharmacy management (page 15).

Personal-Choice Drugs

Although available at a discounted price through a network retail pharmacy, benefits for these drugs are not available under the plan, and the costs of the drugs will not count toward your prescription drug annual deductible or out-of-pocket maximum.

Paying for Prescription Drugs

You are required to pay an annual deductible for your prescriptions each year. Once this amount is met, you pay the copayments listed in the following charts until you meet the prescription drug annual out-of-pocket maximum of \$1,500 for an individual or \$3,000 for a family.

Note: The annual out-of-pocket maximum will increase by \$750 for an individual and \$1,500 for a family in 2014 and every five years thereafter.

2010 PRESCRIPTION DRUG PAYMENTS FOR YOUR EXISTING MEDICAL OPTION (MEDICARE ELIGIBLE)

| | | | |
|-------------------------------------------|-----------------------------------------------------------|--------------|-------|
| Deductible (Retail and Mail Order) | | | \$75 |
| Coinsurance | | | None |
| Copayments | Network Retail Pharmacy (up to a 30-day supply) | Generic | \$10 |
| | | Preferred | \$30 |
| | | Nonpreferred | \$50 |
| | Mail Order (up to a 90-day supply) | Generic | \$20 |
| | | Preferred | \$75 |
| | | Nonpreferred | \$125 |

IMPORTANT

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

IF YOU PURCHASE A BRAND-NAME DRUG WHEN A GENERIC DRUG IS AVAILABLE

If a generic drug is available and you opt for the brand-name equivalent, you will pay the generic drug copayment plus the difference in cost between the generic drug and the brand-name drug you select. This applies regardless of your reason for not using the generic drug, including if your doctor indicates it should not be substituted.



2010 PRESCRIPTION DRUG PAYMENTS FOR YOUR EXISTING MEDICAL OPTION (NOT ELIGIBLE FOR MEDICARE)

| | | | |
|--------------------|------------------------------------------------------------------|--------------|-------------------------------------------|
| Deductible | | | \$50 per covered individual (retail only) |
| Coinsurance | | | None |
| Copayments | Network Retail Pharmacy <i>(up to a 30-day supply)</i> | Generic | \$8 |
| | | Preferred | \$26 |
| | | Nonpreferred | \$50 |
| | Mail Order <i>(up to a 90-day supply)</i> | Generic | \$17 |
| | | Preferred | \$54 |
| | | Nonpreferred | \$108 |

Only copayments for generic and preferred drugs purchased at a network retail pharmacy or through the mail order prescription drug program will count toward your annual out-of-pocket maximum.

2010 PRESCRIPTION DRUG PAYMENTS FOR THE ALTERNATIVE MEDICAL OPTION (FOR MEDICARE OR NON-MEDICARE ELIGIBLE RETIREES)

| | | | |
|-------------------------------------------|------------------------------------------------------------------|--------------|-------|
| Deductible (Retail and Mail Order) | | | \$75 |
| Coinsurance | | | None |
| Copayments | Network Retail Pharmacy <i>(up to a 30-day supply)</i> | Generic | \$10 |
| | | Preferred | \$30 |
| | | Nonpreferred | \$50 |
| | Mail Order <i>(up to a 90-day supply)</i> | Generic | \$20 |
| | | Preferred | \$75 |
| | | Nonpreferred | \$125 |

If you enroll in the Alternative Medical Option or you are Medicare-eligible and enroll in your Existing Regional Medical Option, you are required to meet your \$75 family prescription drug annual deductible before you begin paying copayments.

If you are not Medicare-eligible and you enroll in your Existing Regional Medical Option, there is no mail order annual deductible; therefore copayments apply immediately for mail order. After you have met the \$50 individual retail annual deductible, copayments apply at retail.

Medicare Split Family

If you and your eligible dependents are considered a split family, your eligible prescription drug expenses will accumulate together toward meeting your annual prescription drug deductible and out-of-pocket maximum when you all enroll in the Alternative Medical Option. If you don't all enroll in the Alternative Medical Option, separate prescription drug deductibles and out-of-pocket maximums will apply for those enrolled in each option.

When Prescription Drugs Cost Less Than the Copayments

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

Where to Purchase Prescription Drugs

Network Retail Pharmacy

Use a network retail pharmacy when you need up to a 30-day supply of medications for short-term conditions. Visit the Caremark Web site, or contact a service representative to locate a network pharmacy (see page 17 for details).

When you present your prescription drug ID card at a participating network retail pharmacy, the pharmacist will generally provide you with your prescribed medication, subject to the annual deductible, if applicable, and copayment. If your pharmacist cannot confirm your eligibility or there is a question concerning the coverage of the prescribed medication, the pharmacist may require you to pay the full retail price for the prescription at the time of purchase. In this case, you must submit a claim to the prescription drug claims administrator for reimbursement.

If you go to a network retail pharmacy and do not present your prescription drug ID card, you will be required to pay full price for the prescription. In order to be reimbursed, you must submit a claim. The level of your reimbursement will be as if your prescription had been purchased at a non-network retail pharmacy.

Non-Network Retail Pharmacy

If you purchase your prescription drugs at a non-network retail pharmacy, you must pay for the prescription in full at the time of purchase and then file a claim with CVS Caremark. After you have met your prescription drug annual deductible, if you use a non-network pharmacy, the plan will pay the lesser of either:

- > The amount that it would have paid if you had used a network retail pharmacy.
- > Seventy-five percent of the network retail cost of the prescription.

You will receive no reimbursement if you purchase a maintenance drug at either a network or a non-network retail pharmacy after having filled the prescription twice at a retail pharmacy except as noted in the mail order prescription drug program section on the next page.

IMPORTANT

Prescription drugs purchased at a retail pharmacy cannot be canceled or returned. Federal and state laws require that returned medication must be destroyed and cannot be restocked. As a result, once the pharmacist has dispensed the drug, the order cannot be canceled, and you are responsible for the full copayment. If you are uncertain of your copayment amount, contact the prescription drug claims administrator by either logging on to its Web site or by contacting customer service before you place your order.



IMPORTANT

In most cases, except for the first two fills of the drug during a 12-month period, maintenance drugs will not be covered unless they are purchased through the mail order prescription drug program, even if the prescription is written for a period of less than 30 days.

IMPORTANT

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

Mail Order Prescription Drug Program

If you or a covered dependent takes maintenance medications, your prescription drug program allows you to fill a maintenance prescription written for up to a 30-day supply twice at a retail pharmacy in a 12-month period. Otherwise, you must fill prescriptions for maintenance medications as described below to receive any plan benefit.

Using the CVS Caremark mail order pharmacy, you can have up to a 90-day supply of your maintenance drugs shipped directly to your home. You'll need a prescription from your doctor that is written for up to a 90-day supply, and you'll have to complete a mail-service order form, which you can find on the Caremark Web site.

Once you submit the form, your prescription(s) and the appropriate payment, you'll receive your medication(s) in about two weeks.

Once you've purchased a drug through the mail order pharmacy, you can easily order refills through the Internet, the mail or by telephone.

Beginning Jan. 1, you can also fill maintenance prescriptions written for up to a 90-day supply at any CVS or Longs retail pharmacy. If you currently use the CVS Caremark mail order pharmacy, you can transfer your existing 90-day mail order prescription to a retail CVS or Longs pharmacy starting Jan. 1.

Note: Participants submitting claims for maintenance drugs from a licensed long-term care facility with a National Association of Board Pharmacies (NABP) number will not be required to use the mail order program for their maintenance drugs.

Other Types of Drugs

Specialty Pharmacy Services

Specialty prescription drugs are used in the management of chronic diseases that require complex pharmacy management. The specialty pharmacy services program offers delivery of specialty medications, personalized service and educational support.

After the first time you fill a prescription for a specialty drug at a retail pharmacy, you must purchase the drug through CVS Caremark's specialty pharmacy to receive any plan benefit. If you are later prescribed a different specialty drug, this one-time-only exception will also apply to the purchase of the different drug. Specialty prescription drugs are automatically processed through the specialty pharmacy when you use the mail order prescription drug program.

There is no annual deductible when you obtain a drug through the prescription drug claims administrator's specialty pharmacy. The specialty pharmacy copayment is based on the number of days covered by the fill as follows:

- > Supply for 30 days or less — one-third of the applicable mail order copayment
- > Supply for 31 to 60 days — two-thirds of the applicable mail order copayment
- > Supply for 61 to 90 days — 100 percent of the applicable mail order copayment

Personal-Choice Drugs

Personal-choice drugs include anti-wrinkle injections, erectile-dysfunction agents, hair-growth agents, hair-removal agents, topical anti-aging agents and fertility and diet medications. They are not covered under the prescription drug program. However, you will receive a discount for these drugs at a network retail pharmacy. You'll pay the discounted price plus the pharmacy's dispensing fee.

Purchasing personal-choice drugs does not count toward your prescription drug annual deductible or out-of-pocket maximum, and they are not available through the mail order pharmacy, nor will you receive any reimbursement if you purchase a personal-choice drug at a non-network pharmacy.

If you are hospitalized, the medications you receive while confined are not covered by the prescription drug benefit described here but are covered under your medical or MH/CD inpatient coverage provisions.



Diabetic Supplies

The prescription drug benefit includes the medically necessary equipment and supplies for treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin diabetes when prescribed by a physician. Coverage is provided for lancets, test strips (blood or urine), insulin syringes and glucometers through either a retail pharmacy or the mail order prescription drug program for all categories of diabetes listed.

Birth Control Drugs

The prescription drug benefit provides coverage for the following birth control drugs, without regard to medical necessity:

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

Expenses Not Covered

Following are prescription drug expenses that are not covered by the BellSouth Retiree Medical Assistance Plan:

Note: This is not an all-inclusive list; there may be other expenses that are not covered.

- > Charges for over-the-counter medications and pharmaceutical purchases, whether prescribed by a physician or otherwise. (Exceptions: The prescription drug administrator does cover insulin, diabetic supplies such as blood-testing aids and diagnostic urine tests, and hypodermic needles and syringes prescribed by a physician for use with covered injectables.) Batteries for insulin pumps are not covered.
- > Personal-choice drugs.
- > Charges for services or supplies for care that is educational, developmental, experimental or investigational in nature, unless otherwise specifically noted by the BellSouth Retiree Medical Assistance Plan to be a covered expense. The fact that a service, treatment or device is the only available treatment for a particular condition will not result in coverage if considered to be experimental or investigational in nature for that particular condition.
- > Cosmetic treatment or drugs, digestive aids, vitamins, minerals or other dietary supplements used solely as dietary supplements, whether taken orally or injected, regardless of whether such items are ordered or prescribed by a physician.

Where to Go for More Info

Your claims administrators can help you with any questions you may have.

| WHO | WHY | HOW TO CONTACT |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Medical/surgical claims administrator | <ul style="list-style-type: none"> > Speak with a service representative > Questions about your coverage > Questions about a claim > Locate network providers > Review your personal information > Review health statements (Web only) > Compare hospitals > Estimate cost of treatment | Check your health plan comparison chart during annual enrollment for claims administrator contact information. |
| ValueOptions Mental health/chemical dependency administrator for your Existing Regional Medical Option and the Alternative Medical Option | <ul style="list-style-type: none"> > Speak with a service representative > Questions about your coverage > Questions about a claim > Choose and find a clinician > View eligibility and coverage | 1-800-554-6701 www.achievesolutions.net.att |
| CVS Caremark Prescription drug administrator for your Existing Regional Medical Option and the Alternative Medical Option | <ul style="list-style-type: none"> > Speak with a service representative > Find medication price > Request/download forms > Find a network pharmacy > Order prescription refills > View list of preferred drugs | 1-800-378-8851 www.caremark.com |

In addition to our claims administrators, there are several resources that you can turn to for news and information.

| WHAT | WHY | HOW TO CONTACT |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| access.att.com | <ul style="list-style-type: none"> > Access the latest benefits news and info > Review coverage amounts > Review plan details > Review your summary plan descriptions <p>If this is your first visit, you'll need to:</p> <ul style="list-style-type: none"> > Choose your status. > Choose your appropriate subsidiary. > Save your selections for future visits. | access.att.com > Your Benefits |
| AT&T Benefits Center | <ul style="list-style-type: none"> > Questions about eligibility > Review the cost of coverage > If you have a change-in-status event > View medical plan summary comparison charts, which provide details about your plan > General benefits information | 1-877-722-0020 7 a.m. to 7 p.m. Central time resources.hewitt.com/att 24 hours a day, 7 days a week |



Glossary

*These terms apply only to your prescription drug program.

Administrator. As used in this communication, an administrator is an organization outside AT&T with whom the company has contracted to provide the administration of certain aspects of the company's health and welfare plans.

Annual Deductible. This is the amount of money you must first pay out of pocket for all nonpreventive covered medical, surgical and mental health/chemical dependency services each calendar year before the plan begins to pay benefits. There are separate deductibles for medical and MH/CD network services and non-network services. There is a completely separate prescription drug deductible.

Coinsurance. The percentage of the cost of covered services you pay after meeting your applicable annual deductible. The plan covers the remaining percentage of the allowable charge.

- > After you meet your annual network deductible under the Alternative Medical Option, you are responsible for paying 10 percent of the cost of eligible network services.
- > After you meet your applicable non-network annual deductible under the Alternative Medical Option, you are responsible for paying for 50 percent of the cost of eligible services.

Copayment. A copayment is the fixed charge you are required to pay for certain covered health services after you meet the applicable annual deductible.

Covered Expenses. Covered expenses are incurred charges or expenses (or portion thereof) for treatments, services or supplies to the extent that charges or expenses meet the terms of the BellSouth Retiree Medical Assistance Plan.

Eligible Expenses. Those health care expenses that are covered by the Alternative Medical Option.

***Experimental or Investigational.** Experimental or investigational means that the medical use of a service or supply is still under study and the service or supply is not yet recognized throughout the profession in the United States as safe and effective for diagnosis or treatment. The claim administrator determines if a service or supply shall be considered experimental or investigational. Contact your prescription drug claims administrator for more information.

***Fill.** Fill means a supply provided as directed in the prescription.

***Generic Drug.** A generic drug is an alternative to a brand-name drug that has been determined by the FDA to be:
1) equivalent to the brand-name drug because its active chemical composition is substantially identical, although the drug may vary in color, size or shape; and 2) bioequivalent, meaning it is absorbed by the body at the same rate as the brand-name drug.

***Mail Order.** Mail Order is the purchase of prescription drugs by a covered person or eligible dependent using the prescription drug claims administrator's mail order processing program according to the terms of the program.

***Maintenance Drugs.** A maintenance drug is a drug generally prescribed for chronic or long-term medical conditions, including, but not limited to, diabetes or high cholesterol. The designation of a maintenance drug is determined by the prescription drug claims administrator. There may be differences between claims administrators.

***Medically Necessary.** Medically necessary means, with respect to each service or supply that the service or supply is needed and is appropriately provided, as evidenced by meeting all of the requirements as determined by the claims administrator. Contact your prescription drug claims administrator for more information.

Network. Health care providers, hospitals and pharmacies that contract with the administrator to provide services at negotiated rates.

***Network Retail Cost.** Network retail cost (as applied to prescription drug benefits) means the cost to the program of the medication, including the copayment, if it was purchased using the covered person's prescription drug card, at a retail network pharmacy.

***Network Retail Pharmacy.** Network retail pharmacy means a retail pharmacy that is in the prescription drug program claims administrator's network of participating retail pharmacies and has a participation agreement in effect with the prescription drug program claims administrator.

Non-Network Provider. A physician, facility or pharmacy that is not a member of the plan's network of providers.

***Non-Network Retail Pharmacy.** Non-network retail pharmacy means a retail pharmacy that is not in the prescription drug program claims administrator's network of participating retail pharmacies and does not have a participation agreement in effect with the prescription drug program claims administrator.

***Nonpreferred Brand Drug.** A nonpreferred brand drug is a brand-name prescription drug that is not included on the prescription drug claims administrator's preferred drug benefit guide and may or may not have a generic drug equivalent.

Nonpreventive Care Services. Generally, these are the services that are provided to diagnose or treat an existing illness, injury or condition.

Out-of-Pocket Maximum. Under the Alternative Medical Option, this is the maximum amount of costs from coinsurance that you could pay out of your pocket each year. Any contributions that you pay to participate in the plan or any money you pay toward your annual deductible does not count toward your out-of-pocket maximum. There are separate out-of-pocket maximums for medical and MH/CD network/ONA services and non-network services. Under the prescription drug program, this is the maximum amount of costs from copayments that you could pay out of your pocket for prescription drugs each year.

***Pharmacy.** A pharmacy is an establishment licensed by the state to dispense prescription drugs prescribed by an authorized licensed provider.

***Preferred Brand Drug.** A preferred brand drug is a brand-name prescription drug that is included in the preferred drug benefit guide.

***Preferred Drug Benefit Guide.** Preferred drug benefit guide means a guide that identifies the U.S. Food and Drug Administration-approved drugs that the prescription drug program claims administrator's panel of doctors and pharmacists has determined to be safe and effective: the preferred alternatives are generally more cost-effective than nonpreferred brand-name drugs. The preferred drug benefit guide is generally revised on a quarterly basis and may change throughout the plan year.

***Prescription Drug.** Prescription drug means a drug or medicine approved by the United States Food and Drug Administration for general use by the public, requiring a prescription by a licensed pharmacist or physician.

Preventive Care Services. Generally, these are the services and procedures that are administered for routine, precautionary purposes rather than treatment or services for an existing illness, injury or condition.

***Specialty Prescription Drugs.** A specialty prescription drug is a drug used in the management of certain chronic diseases, such as hemophilia, growth-hormone deficiency, multiple sclerosis, immune disorders and hepatitis C, requiring complex pharmacy management.



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