Summary Plan Description

Important Benefits Information

AT&T Southeast Disability Benefits Program

This is an updated summary plan description (SPD) for the AT&T Southeast Disability Benefits Program, a component program under the AT&T Umbrella Benefit Plan No. 1. This SPD replaces your existing BellSouth Short-Term Disability Plan and BellSouth Long-Term Disability Plan for Non-Salaried Employees SPDs dated Jan. 1, 2006.

Please keep this document for future reference.

DISTRIBUTION

Distributed to all Bargained Employees (including employees on Leave of Absence and recipients of Short-Term Disability or Long-Term Disability Benefits) in the following Bargaining Units: AT&T Billing Southeast, LLC - CWA District 3, AT&T Southeast Core Contract - CWA District 3, (which includes AT&T Operations, Inc., AT&T Services, Inc., BellSouth Communications Systems, LLC, and BellSouth Telecommunications, Inc.), BellSouth Advertising & Publishing Corporation - CWA District 3, and BellSouth Telecommunications, Inc. (Internet Services) - CWA District 3

Distributed to all Nonmanagement Nonunion Employees (including employees on Leave of Absence and recipients of Short-Term Disability or Long-Term Disability Benefits) in the following Participating Companies: BellSouth Advertising & Publishing Corporation, Berry Networks, Inc. and L.M. Berry & Company.

NIN 78-21848

IMPORTANT INFORMATION

This SPD along with the AT&T Umbrella Benefit Plan No. 1 is the official document for the benefits offered under the AT&T Southeast Disability Benefits Program (the Program). It will govern and be the final authority on the terms of the Program. AT&T reserves the right to terminate or amend any and all of its employee benefit plans or programs, at any time for any reason. Participation in this Program 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 Southeast Disability Benefits Program, a component program of the AT&T Umbrella Benefit Plan No. 1. This SPD, together with the summaries of material modifications (SMMs) issued for this Program constitute your SPD for this Program.

What action do I need to take?

You should review this SPD.

How Do I Use This Document?

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

Also, you need to keep your SPDs and SMMs for future reference. They are your primary resources for questions about the Program.

Questions?

If you have questions regarding information in this SPD, contact the Claims Administrator. See the “Contact Information” section for information on how to contact the Claims Administrator.

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BRIEF OVERVIEW OF PROGRAM BENEFITS

KEY POINTS

A. The Program, which is 100 percent paid by your employer, provides Short-Term Disability Benefits and Long-Term Disability Benefits to Eligible Employees.

B. See the "Eligibility for the Program" section for more information on eligibility.

The AT&T Southeast Disability Benefits Program (the Program) provides for ongoing income if you become Disabled and unable to work. Your employer pays the full cost of your participation in the Program.

Your Short-Term and Long-Term Disability Benefits work together to provide for your disability coverage. Here's how:

- Short-Term Disability Benefits begin on the eighth consecutive calendar Day of Absence from work as a result of an approved Disability.
- Short-Term Disability Benefits may continue for up to 52 weeks, provided you remain Disabled.
- The Short-Term Disability Benefits and the other sources of income you receive are designed to replace 50 percent or 100 percent of your Pay, based on your Term of Employment.
- You may be eligible for Long-Term Disability Benefits at the end of the 52-week period of Short-Term Disability Benefits.
- Your Long-Term Disability Benefits and the other sources of income you receive are designed to replace 50 percent of your Pay.
- Your Long-Term Disability Benefits can continue to age 65 (or beyond if your Disability begins after age 60), provided you remain Disabled.

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINT

A. This SPD applies to you if you became Disabled on or after Jan. 1, 2011.

This document describes the disability benefits offered to Eligible Employees eligible to receive benefits from the AT&T Southeast Disability Benefits Program and is intended to serve as the SPD as required by the Employee Retirement Income Security Act of 1974 (ERISA). This SPD describes the Program and its amendments as of Jan. 1, 2011, and replaces all prior versions of the BellSouth Short Term Disability Plan and BellSouth Long Term Disability Plan for Non-Salaried Employees. This Program applies if you became Disabled on or after Jan. 1, 2011. If you became Disabled before Jan. 1, 2011, the terms of the previous BellSouth Short Term Disability Plan and BellSouth Long Term Disability Plan for Non-Salaried Employees apply.

This Program is one of the benefit programs offered by AT&T Inc. under the AT&T Umbrella Benefit Plan No. 1.

Terms that are capitalized are explained in the text of this SPD or defined in the "Definitions" section of this SPD.

ELIGIBILITY FOR THE PROGRAM

KEY POINTS

A. You must be an Eligible Employee (full-time or part-time) of a Participating Company who is classified as a Regular, Term or Temporary Employee and covered by certain collective bargaining agreements to be eligible for the Program.

B. Eligible Employees are eligible for Short-Term Disability Benefits after completing a six-month Term of Employment.

C. Eligible Employees are eligible for Long-Term Disability Benefits after completing a 12-month Term of Employment.

*D. Term and Temporary Employees are **not** eligible for Long-Term Disability Benefits.*

To be eligible for the AT&T Southeast Disability Benefits Program, you must:

- Be an Eligible Employee of a Participating Company,
- Be a Bargained Employee covered by one of the collective bargaining agreements listed in the "Applicable Collective Bargaining Agreements" section, and
- Have completed a six-month Term of Employment to be eligible for Short-Term Disability Benefits, or have completed a 12-month Term of Employment to be eligible for Long-Term Disability Benefits.

Each of these requirements is explained in the following sections.

Eligible Employee

To be considered an Eligible Employee, you must be on the active payroll of a Participating Company listed in the next section of this SPD and covered by one of the applicable collective bargaining agreements listed in the "Applicable Collective Bargaining Agreements" section. You must also be receiving a regular and stated compensation for services rendered to a Participating Company as a Regular, Term, or Temporary Employee (full-time or part-time).

✷ **Special Rule for Term Employees and Temporary Employees**

*Term Employees and Temporary Employees are eligible for Short-Term Disability Benefits under the Program only. If you are a Term Employee or a Temporary Employee, you are **not** eligible for Long-Term Disability Benefits.*

You are **not** eligible to participate in the Program if you are classified by a Participating Company as a(n):

- Occasional Employee.
- Leased Employee.
- Independent contractor.
- Nonresident alien employed outside of the United States.
- Bargained Employee who is temporarily promoted to a management position (also known as an acting title).

Important: If you are in either of the following Bargaining Units you are **not** eligible to participate in the Program:

- BellSouth Telecommunications, Inc. (National Directory & Customer Assistance) - CWA District 3
- BellSouth Telecommunications, Inc. (Utility Operations) - CWA District 3

You may be eligible to participate in the AT&T Southeast Disability Benefits Program for Special Represented Employees. Contact the Claims Administrator to see if you are eligible for the AT&T Southeast Disability Benefits Program for Special Represented Employees. See the "Contact Information" section for information on how to contact the Claims Administrator.

You are also **not** eligible to participate in the Program if you are eligible for disability coverage (long-term or short-term) under any other disability benefit program sponsored by AT&T, or if your wages are paid by an employer that is not a Participating Company.

Eligibility During a Leave of Absence

You are eligible for Short-Term Disability Benefits while you are on a Short-Term Disability Appeal Leave of Absence. You also may be considered eligible if you are granted a Leave of Absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) or if your approved Leave of Absence provides for continued eligibility for this Program. You are **not** eligible for Short-Term Disability Benefits at the expiration of a Leave of Absence unless the applicable Leave of Absence policy contains mandatory return rights. Refer to the AT&T Southeast Leave of Absence Policy for more information about how a Leave of Absence affects your eligibility for this Program.

Eligibility While Suspended From Work

You are **not** eligible for Short-Term Disability Benefits from the Program while you are absent from work because of a disciplinary suspension. If you become Disabled during a disciplinary suspension, you will not be entitled to benefits during the period of suspension. Your first Day of Absence will be the first day following the last day of your suspension. Benefits may be payable on the eighth consecutive Day of Absence following the suspension period.

Participating Companies

You must be an Eligible Employee of one of the following AT&T-affiliated companies — known as Participating Companies — to be eligible for this Program:

- AT&T Billing Southeast, LLC
- AT&T Operations, Inc.
- AT&T Services, Inc.
- BellSouth Advertising & Publishing Corporation
- BellSouth Communications Systems, LLC
- BellSouth Telecommunications, Inc.
- Berry Networks, Inc.
- L.M. Berry and Company

Applicable Collective Bargaining Agreements

You are eligible for this Program only if you are a Bargained Employee covered by one of the collective bargaining agreements listed below:

- AT&T Billing Southeast, LLC. - CWA District 3
- AT&T Southeast Core Contract - CWA District 3
    - AT&T Operations, Inc.
    - AT&T Services, Inc.
    - BellSouth Communications Systems, LLC
    - BellSouth Telecommunications, Inc.
- BellSouth Advertising & Publishing Corporation - CWA District 3
- BellSouth Telecommunications, Inc. (Internet Services) - CWA District 3

Generally, you are a Bargaining Unit Employee if:

- Your job title and classification are included in a collective bargaining agreement between your Employer and a union.
- You are a “confidential employee” as defined by the National Labor Relations Act.
- You are a nonmanagement, nonunion Employee employed by any of the following Participating Companies:
    - BellSouth Advertising & Publishing Corporation
    - Berry Networks, Inc
    - L.M. Berry & Company

Term of Employment

You must have a six-month Term of Employment to be eligible for Short-Term Disability Benefits, or a 12-month Term of Employment to be eligible for Long-Term Disability Benefits.

Term of Employment – as defined in the Southeast Program of the AT&T Pension Benefit Plan - (also known as seniority) means a period of employment in the service of AT&T or one or more members of the AT&T Group of Companies as determined by your Participating Company and the Plan Administrator.

* **Special Rule for Long-Term Disability Benefits**

  You must also be actively at work on the day you attain 12 months of Term of Employment. If you are not actively at work on that day, you will become eligible for Long-Term Disability Benefits on the date you return to actively-at-work status. You will be considered actively at work for your employer on:

  - *A scheduled work day if you are performing your regular work duties (1) on a full-time basis on that day if you are a full-time employee, or (2) on a part-time basis if you are a part-time employee, at either your employer's place of business, or at some location to which your employer's business requires you to travel, or*
  - *A day which is not a scheduled work day, if you were actively at work on the preceding scheduled work day.*

Important: Any period for which you are receiving Long-Term Disability Benefits will not be included in your Term of Employment.

ENROLLMENT

If you are an Eligible Employee, you are automatically enrolled in the Program. There are no election forms to complete.

CONTRIBUTIONS

Your employer pays the entire cost of the Program — you are not required to contribute.

WHEN COVERAGE BEGINS AND ENDS

Coverage Begins

Your coverage under this Program begins on the date you fulfill all eligibility requirements, including the Term of Employment requirement. See the "Eligibility for the Program" section for more information on eligibility. To be covered under this Program means that you are eligible for Program benefits for an absence as a result of a Disability.

Important: If you are transferred into a job title covered by this Program from another Interchange Company and your coverage under the previous company's plan ends solely as a result of the transfer, the following rules apply unless another arrangement is negotiated by your union or previous employer:

(1) If you are receiving short-term disability benefits at the time of the transfer, then you will be covered immediately by this Program, but the length of time for which you will receive Short-Term Disability Benefits and the amount you receive will take into account the period of time you received benefits from the previous plan. All other Program rules and conditions will apply.

(2) If you are not receiving short-term disability benefits at the time of the transfer and became Disabled after the transfer, the relapse rules under this Program will be applied, taking into account any short-term disability benefits you received from the previous plan. All other Program rules and conditions will apply.

Coverage Ends

You are no longer covered under this Program on the date you cease to fulfill any of the eligibility requirements described in this document (See the "Eligibility for the Program" section for more information on eligibility). Generally, your coverage under the Program ends when your employment is terminated for any reason, but you will continue to be covered by the Program after termination if you are receiving Long-Term Disability Benefits from this Program.

Important: If your employment for a Participating Company terminates for any reason, including but not limited to retirement or layoff, prior to the expiration of the 52-week maximum of Short-Term Disability Benefits, you will not be eligible for Long-Term Disability Benefits from the Program.

YOUR SHORT-TERM DISABILITY BENEFITS

KEY POINTS

A. *Short-Term Disability Benefits under the Program are available if you are determined by the Claims Administrator to have a Disability. Short-Term Disability Benefits under the Program are payable on the eighth consecutive calendar Day of Absence as a result of an approved Disability.*

B. *The amount of Short-Term Disability Benefits depends on your Pay and your Term of Employment.*

C. *Short-Term Disability Benefits are payable for a maximum of 52 weeks.*

D. *Your Short-Term Disability Benefits will be reduced by certain other income sources known as Offsets.*

This Program provides Short-Term Disability Benefits for up to 52 weeks while you are Disabled.

When You Are Considered Disabled

You are considered disabled for purposes of Short-Term Disability Benefits if you are found by the Claims Administrator, in its sole discretion, to be Disabled. Disabled means that you have a medical condition supported by objective Medical Evidence, which:

- Causes you to be unable to perform any type of work as a result of a physical or mental illness or an accidental injury, or
- Results in your receiving treatment that qualifies as a Chemical Dependency Confinement.

You are considered unable to perform any type of work when you are unable to perform all of the following:

- Your regular job with or without accommodations,
- Any other Participating Company job, with or without accommodations,
- Any job outside a Participating Company which is comparable in skills and functions to any Participating Company job,
- Temporary modified duties.

You are not Disabled unless objective Medical Evidence demonstrates that you cannot perform the above functions, regardless of whether such work is actually available.

A Chemical Dependency Confinement is any period of continuous confinement for drug or alcohol dependency, which is approved by or covered by your AT&T group health plan. If you waived medical coverage under your AT&T group health plan, the Claims Administrator, in its sole discretion, will determine if a confinement would have been approved or covered by the applicable AT&T group health plan.

Filing for Short-Term Disability Benefits

In order to be considered for Short-Term Disability Benefits under the Program, you must:

- Be an Eligible Employee. You must meet the eligibility requirements as of the eighth consecutive calendar Day of Absence from work as a result of a Disability. See the "Eligibility for the Program" section for more information on eligibility.
- Contact your supervisor, or appropriate designated representative, as soon as reasonably possible to report your absence.
- Contact the Claims Administrator as soon as reasonably possible, but no later than 60 days after your first Day of Absence.

> **Important:** Your claim for benefits under the Program is considered filed when you notify the Claims Administrator. You will **not** be entitled to benefits under the Program for any absence that occurs before you notify the Claims Administrator, unless the Claims Administrator, in its sole discretion, determines that the delay was unavoidable.

- Take proper care of yourself and obtain appropriate professional treatment.
- Unless your condition is of a severity that would prevent you from doing so, cooperate and communicate with the Claims Administrator regarding your Disability including:
    - Report for and permit any examination, such as a medical examination by a physician designated by the Claims Administrator or a functional capacity evaluation, if the Claims Administrator requires this examination. The Claims Administrator may require medical examinations it deems necessary in its discretion in order to evaluate whether you are Disabled for the following reasons:
        - When the available, objective Medical Evidence from your treating physician is insufficient to evaluate your ability to return to work in a current or modified assignment;
        - When the course of your treatment does not appear to address the Disability documented by your medical records;
        - When it is necessary to verify your ability to perform job functions;
        - When the Claims Administrator seeks to validate or determine the appropriateness of any permanent restrictions; or
        - When the available objective Medical Evidence is insufficient to support a disability determination; however, your treating physician does not agree to certify that you are able to return to work and you have not returned to work. If termination of your employment is being considered because you have not returned to work and a medical examination has not been performed, a medical examination will be scheduled.

Important: If you do not comply, or if you prevent the necessary examination (for example, by staying away from home without making arrangements with the Claims Administrator or failing to provide satisfactory reasons for not making arrangements with the Claims Administrator and furnishing necessary evidence), you will **not** be entitled to Short-Term Disability Benefits. If you initially refuse a medical examination arranged by the Claims Administrator and then reconsider, you will **not** be entitled to Benefits for the period of refusal, even if the subsequent medical examination determines that you are Disabled.

- Periodically furnish all necessary and appropriate objective Medical Evidence of your Disability from you, your physician or medical provider when requested by the Claims Administrator,
- Ensure that your medical providers cooperate with the Claims Administrator to provide all necessary information to the Claims Administrator in a timely manner.
- Provide your physician or other medical provider with a signed copy of the medical release form provided by the Claims Administrator.

Important: You are responsible for maintaining contact with the Claims Administrator and cooperating with the Claims Administrator as the Claims Administrator may require.

Contact the Claims Administrator to obtain permission if you plan to recuperate away from your home.

Important: Travel is not permitted without prior permission of the Claims Administrator. Contact the Claims Administrator if you need to recuperate away from home. Your physician or other medical provider **must** approve this as well. Benefits are **not** payable unless the Claims Administrator has approved this request.

Only the Claims Administrator (and its delegates) have the discretion to determine whether you have a disability that qualifies you for Short-Term Disability Benefits under the Program. If you do not file your claim for Short-Term Disability Benefits within 60 days of your first Day of Absence, the Claims Administrator will deny your claim and no Short-Term Disability Benefits will be payable. See the "Additional Information About Filing a Claim for Benefits Under the Program" section for information about filing a claim.

When Short-Term Disability Benefits Begin

Your Short-Term Disability Benefits begin on the eighth consecutive calendar day that you are away from work as a result of an approved Disability (unless your absence begins within two weeks of a previous short-term disability absence -- see the "Relapses" section).

Any scheduled absences, including but not limited to a vacation day, optional holiday, excused work day, departmental leave, or suspension, do not count as a Day of Absence for purposes of satisfying the seven-consecutive-day waiting period. In addition, if the eighth calendar day falls on your normally scheduled day off or on a scheduled optional holiday and you return to work the following day, then no benefit absence would have occurred.

Example: Mary is an Eligible Employee who is first absent from work as a result of an illness or injury beginning on Dec. 16. If she is absent as a result of the illness or injury until Dec. 23, her Short-Term Disability Benefits, if approved, would begin on Dec. 23 (eighth calendar Day of Absence). Note that if Mary's first Day of Absence is Dec. 18, her eighth consecutive calendar Day of Absence is Dec. 25 — a holiday on which Mary is not scheduled to work. If Mary returns to work on Dec. 26, she will not have had a short-term disability under the Program. If she is still absent on Dec. 26 as a result of her approved disability, she will begin receiving Short-Term Disability Benefits, if approved.

If the Company determines that your injury or illness is a workers' compensation injury or illness, and that the associated absence is medically necessary, the applicable waiting period for pay treatment otherwise provided by the applicable collective bargaining agreement will be waived. This payment is made by your department and is not a Short-Term Disability Benefit.

How a Leave of Absence Affects When Your Short-Term Disability Benefits Begin

If you become Disabled during a Leave of Absence (with the exception of the Short Term Disability Appeal Leave of Absence), you are **not** eligible for Short-Term Disability Benefits during the absence and will **not** be entitled to benefits during the leave or at the expiration of the leave, unless the leave has mandatory return rights. Following a leave with mandatory return rights, the first full Day of Absence is the date of your mandatory return. Benefits may be payable beginning on the eighth consecutive Day of Absence from the date of mandatory return.

If you become Disabled while on a departmental Leave of Absence (and before a formal leave is authorized), your first full Day of Absence is the day you were scheduled to return to work. Refer to the AT&T Southeast Leave of Absence Policy for more information on any Leave of Absence you may be eligible to receive.

Amount and Duration of Short-Term Disability Benefits

Your Short-Term Disability Benefits can last up to 52 weeks if you remain Disabled. The amount of your Short-Term Disability Benefits depends upon your Term of Employment and Pay, both as of your eighth Day of Absence, as the chart below shows.

Term of Employment	Weeks at full Pay (100 Percent of Pay)	Weeks at half Pay (50 Percent of Pay)
6 months to 2 years	0	52
2 but less than 5 years	4	48
5 but less than 15 years	13	39
15 but less than 20 years	26	26
20 but less than 25 years	39	13
25 or more years	52	0

✷ Special Rule for Limiting Disability Payments Resulting From Chemical Dependency Confinement

There are limits to the Short-Term Disability Benefits payable to you if your Disability is solely because of Chemical Dependency Confinement (see the "When You Are Considered Disabled" section). Your Benefits will be payable for only one such confinement per calendar year and only for a period of 13 consecutive weeks.

Pay

Your Pay is your weekly base Pay, including evening and night differential, if applicable, based on your normally scheduled hours of work per week as a full-time or part-time employee as determined by the Company's payroll records. For Sales Consultants paid pursuant to a leveraged compensation plan, Pay will be based on base wages plus 100 percent of the target incentive amount, as defined under the collective bargaining agreement. For other commissioned sales representatives, Pay will be based on your average weekly earnings or the non-selling rate, whichever is applicable. Pay shall not include short-term awards, bonuses, and any other non-periodic payments. Your normally scheduled hours are those hours that you generally are scheduled to work, excluding additional special hours worked such as overtime, special projects, and training.

Offsets

Your Short-Term Disability Benefits will be offset (reduced) by the amount of any other disability or injury-related payments that you receive by operation of law (in effect now or in the future), including but not limited to:

- Workers' Compensation Benefits. If you are unable to work as a result of a work-related short-term disability, you may be eligible to receive Workers' Compensation Benefits. Workers' Compensation Benefits, including permanent disability, will reduce your Short-Term Disability Benefits.

- State Disability Insurance (SDI) and other benefits of the same character under any state or federal disability law, such as benefits under disability insurance laws of any other state, or the functional equivalent of Workers' Compensation Benefits. The Plan Administrator has the sole discretion to determine what payments under current or future laws are of the same general character as benefits under the Program.

This means that if the amount you receive from all of the Offsets listed above is less than the applicable percentage of your Pay, Short-Term Disability Benefits provide additional payments to bring your total disability income up to that level. If your combined income from the Offsets listed above is equal to or greater than the applicable percentage of your Pay, you will not receive payments from the Program. The Program may seek to recover any overpayments that you receive.

Example: Suppose you have a five-year Term of Employment and your weekly Pay is $700. Suppose further that your Disability was the result of an on-the-job injury and you are receiving Workers' Compensation Benefits of $490 per week. The Claims Administrator approves Short-Term Disability Benefits at 100 percent of $700 per week. Since you are receiving Workers' Compensation Benefits of $490 per week, you will receive Short-Term Disability Benefits of $210 per week to bring your total weekly benefit up to $700 (equal to 100 percent of Pay).

If your short-term disability is still approved by the Claims Administrator after 13 weeks, you will be eligible to receive Short-Term Disability Benefits at half Pay. However, if Workers' Compensation Benefits of $490 per week continue, you will not receive any payments from the Program because the $490 per week of Workers' Compensation Benefits is more than Short-Term Disability Benefits at half Pay.

Furthermore, if Short-Term Disability Benefits and Offsets are payable or awarded at different times for the same periods of Disability, Short-Term Disability Benefits will be adjusted to take the Offsets into account.

Example: If you receive retroactive Workers' Compensation Benefits four months after you have begun receiving Short-Term Disability Benefits, you will be considered to have been overpaid by the Program for those first four months, and future Short-Term Disability Benefits will be reduced to reflect the future Workers' Compensation Benefits and to recapture the past overpayments. In some cases, the Program may determine that you have received an overpayment for which repayment to the Program will be necessary.

There is no time limit on when Offsets can be applied. Failure to apply an Offset as soon as it is available will not constitute a waiver by the Program of offset rights or otherwise prevent their later exercise.

Important: No Short-Term Disability Benefits payable under the Program will be reduced by reason of any governmental benefit payable for military service or Social Security Disability Insurance Benefits.

Relapses

If you return to work following a short-term disability and experience a relapse, you may be eligible for Short-Term Disability Benefits for your relapse depending upon the length of your original short-term disability and the length of time for which you returned to active work. Note that this section applies whether your relapse is for the same disability or a different one. Short-Term Disability Benefits will be determined based upon your Pay and Term of Employment at the time of the subsequent absence.

If you return to work for 13 full weeks of continuous performance of duty following your original short-term disability and are again Disabled, you are eligible for a new 52 weeks of Short-Term Disability Benefits on the eighth consecutive calendar Day of Absence. Short-Term Disability Benefits will be determined without regard to prior Short-Term Disability Benefit payments.

To determine whether you have worked for 13 full weeks of continuous performance of duty, your continuous performance of duty is broken when any of the following occurs:

- Absence due to sickness of more than seven consecutive calendar days;
- Absence without credit for service under the Southeast Program of the AT&T Pension Benefit Plan;
- Absence of more than one month, with credit for the one month of service;
- Cumulative vacation in excess of one week (i.e., total vacation hours exceeding 37.5 or 40 hours, as applicable).

Only one week of vacation (a normal work week of 37.5 or 40 hours whether or not those days or hours are taken consecutively or in segments) will be counted toward the 13 weeks of continuous performance of duty. Vacation in excess of one week:

- Will not count as part of the 13 weeks of continuous performance of duty;
- Will not be used in calculating the time required to meet the 13 weeks of continuous performance of duty; and
- Will not reduce the remaining time period required to meet the 13 weeks of continuous performance of duty.

If you return to work for 14 days or more but less than 13 weeks, and you are again Disabled, you are **not** eligible for a new 52-week maximum benefit. Your Short-Term Disability Benefits will begin again on the eighth consecutive Day of Absence. Your earlier period of disability absence will be counted with your later period of disability absence, and your maximum benefit will be a total of 52 weeks. Your previous disability absence will be counted in determining whether you are eligible for full Pay, half Pay or both. This is true whether or not the two absences relate to the same disability.

> **Example:** Suppose Mary became disabled and was unable to work for four weeks (a one-week waiting period and three weeks of Short-Term Disability Benefits). She has four years of service. She returned to work and after 20 days was again Disabled.
>
> Since Mary had four years of service, she is eligible for four weeks of full Pay and 48 weeks of half Pay. After the seven-day waiting period, Mary received three weeks of full Pay. After her relapse, Mary will have another seven-day waiting period. After the waiting period, Mary can receive Short-Term Disability Benefits on the eighth day of this absence. If she remains Disabled, she will be eligible to receive the remaining one week of full Pay and 48 weeks of half Pay.

If you return to work for less than 14 days and are again Disabled, you are not eligible for a new 52-week maximum benefit. Your Short-Term Disability Benefits will begin on the first subsequent Day of Absence. Your prior period of disability absence will be counted with your later period of disability absence, and your maximum benefit will be a total of 52 weeks. Your previous disability absence will be counted in determining whether you are eligible for full Pay, half Pay or both. This is true whether or not the two absences relate to the same disability.

Example: Suppose Don became disabled and was unable to work for six weeks (a one-week waiting period and five weeks of Short-Term Disability Benefits). He has four years of service. He returned to work and within two weeks was again Disabled.

Since Don had four years of service, he is eligible for four weeks of full Pay and 48 weeks of half Pay. After the seven-day waiting period, Don received four weeks of full Pay and one week of half Pay. After his relapse, Don can receive Short-Term Disability Benefits on the first day of this absence. If he remains Disabled, he will be eligible to receive the remaining 47 weeks of half Pay.

If you return to work for less than 13 full weeks after having received the maximum 52 weeks of Short-Term Disability Benefits during your previous disability absence and you are again Disabled, you may be eligible for Long-Term Disability Benefits. If approved by the Claims Administrator, your Long-Term Disability Benefits would begin concurrent with your termination from the active payroll.

Returning To Work Temporarily For Partial Days

If there is satisfactory objective Medical Evidence that supports your need to temporarily return to work on a modified schedule, the Claims Administrator may approve Partial-Day Benefits under Short-Term Disability Benefits for a reasonable period of time.

Partial-Day Benefits normally follow a prolonged period of absence and are paid only when it is expected that you will resume full duty within a short period of time (typically not more than two weeks) or such longer period as the Claims Administrator may allow based upon extenuating circumstances and as it determines in its sole discretion. You must provide continued satisfactory objective Medical Evidence consistent with your Disability that supports your continued need for a temporary modified work schedule, as determined by the Claims Administrator in its sole discretion.

Partial-Day Benefits are payable if:

- You return to work on a partial-day basis immediately following a benefit absence for which Short-Term Disability Benefits were paid for less than 52 weeks, or
- You have a relapse that limits you to work for a partial day within 14 calendar days of returning from an absence for which Short-Term Disability Benefits were paid for less than 52 weeks.

If you return to work for partial days, your Short-Term Disability Benefits will be calculated using the same level of Short-Term Disability Benefits (full Pay or half Pay) that you would have received had you remained on a full-time, short-term disability absence. That is, the Short-Term Disability Benefits otherwise payable to you will be adjusted to reflect only the time you are not working. If you are in full Pay benefit status, you will receive wages (for time worked) plus partial day Short-Term Disability Benefits equal to your full Pay.

> **Example:** Your weekly Pay is $800 and you become Disabled and are entitled to full Pay as your Short-Term Disability Benefit. You return to work for four hours a day, for which you earn $400 per week. Your Short-Term Disability Benefits will be the remaining $400 so that your total income will be equal to your full Pay of $800 per week.

If you are in half Pay status, in addition to the wages you earn for your partial day work, you will receive Short-Term Disability Benefits equal to one-half the difference between the wages you receive and your full Pay.

> **Example:** Your weekly Pay is $800, and you become Disabled and are entitled to half Pay. You return to work for four hours a day, for which you earn $400 per week. Your Short-Term Disability Benefits will be $200 per week—which is one-half the difference between the $400 wages you earn and your full Pay.

If you return to work and receive Partial-Day Benefits, but during your full-day disability absence completed a Term of Employment period that would otherwise entitle you to increased benefits, you are eligible for such increase while you receive Partial-Day Benefits.

Partial-Day Benefits will be discontinued when any of the following events occur (whichever is earliest):

- You fail to provide satisfactory objective Medical Evidence of continued need for a temporary modified work schedule;
- You are able to resume your normal schedule for a period of 14 consecutive calendar days;
- You relapse and become Disabled as defined in the "When You Are Considered Disabled" section;
- You exhaust a combined 52 weeks of Partial-Day Benefits and full-time benefits; or
- The Claims Administrator determines that your ability to work on a permanent basis is limited to part-time duty.

Each partial day of benefits is counted as a full day of benefits for the purposes of calculating the combined 52 weeks of benefits. If you relapse to Disability prior to exhausting the 52-week maximum, Partial-Day Benefits previously paid will not count toward the 52 weeks of full Short-Term Disability Benefits.

How Benefits Are Paid

Your Short-Term Disability Benefits accrue and ordinarily will be paid as soon as possible following a determination that you have a short-term disability and at the same time as wages or salary are paid by the Participating Company, except that arrears may be paid in a single sum (calculated using the factors described in the "Pay" section). AT&T may, in its discretion, direct that Short-Term Disability Benefits be paid monthly. Additionally, under current law, Short-Term Disability Benefits are considered federal taxable income.

Except during the time you are receiving Partial-Day Benefits, you are not entitled to receive Short-Term Disability Benefits for any period of time during which wages are paid to you by a

Participating Company or an affiliated company or a company which has entered into an arrangement for an interchange of benefits obligation.

Conversion to Lump Sum

If you are gravely injured or ill, you may request payment in a lump sum representing the present value of the Short-Term Disability Benefits that you would receive if your short-term disability continues as would reasonably be expected. The present value will be computed on a basis chosen by the Plan Administrator, with your agreement that this lump sum is paid in full and final settlement of all claims under the Program and against your Participating Company and related parties on account of your illness or injury. The Plan Administrator will make the decision in its sole discretion, whether to pay you a lump sum. Your request should be made according to the appeal procedures of this Program. If you receive a lump sum settlement under this section, you shall not in any event be eligible for any benefits under the Long-Term Disability portion of the Program or any Disability Pension under the Southeast Program of the AT&T Pension Benefit Plan. See the "How to File an Appeal" section for more information.

When Your Short-Term Disability Benefits End

Your Short-Term Disability Benefits end on the earliest day any of the following events occur:

- You return to work with the AT&T Group of Companies or any other employer. (Exception: If your return to work is as a result of the Claims Administrator determining, in its sole discretion, that you are eligible for Partial Disability benefits).
- Your employment with your employer is terminated for any reason (including death, involuntary termination, resignation, retirement or layoff).
- For Temporary Employees and Term Employees, your work completion date (even if you are receiving Short-Term Disability Benefits on that date).
- You transfer employment to an employee group that is not eligible to participate in this Program, or the bargaining unit of which you are a member ceases to be covered by the Program by amendment or otherwise.

Benefits are **not** payable:

- If you fail to make a claim within 60 days of your first Day of Absence on account of Disability, unless the Claims Administrator, in its sole discretion, determines that a delay was unavoidable.
- For periods of time when you are not determined to be Disabled for purposes of Short-Term Disability Benefits, as determined by the Claims Administrator in its discretion, except that benefits may be continued following a period of disability as provided for periods in the "Administrative Denial" section.
- For a period of time during which you fail to comply with the terms of the Program.
- If you travel away from home without obtaining prior permission from the Claims Administrator for a specific period of recuperation. Each request for travel is determined on an individual basis. You must provide satisfactory proof of Disability while away from home.

Important: Travel is not permitted without prior permission of the Claims Administrator. Contact the Claims Administrator if you need to recuperate away from home. Your physician or other medical provider must approve this as well. No benefits are payable unless the Claims Administrator has approved this request based on medical necessity.

- If you refuse a medical examination or otherwise fail to cooperate with the Claims Administrator with regard to your claim for benefits. If you initially refuse a medical examination, and then reconsider, you are not entitled to Short-Term Disability Benefits for the period of refusal, even if the medical examination determines that you are Disabled.
- If a legal claim is brought by you or another person on your behalf against your Participating Company or any other AT&T company or one of their employees or representatives, and that claim is based upon or related to an illness or injury for which benefits were or could have been provided under this Program, except for claims that are brought to enforce the provisions of this Program.

Administrative Denial

If you are no longer considered to be Disabled and you do not return to work, Short-Term Disability Benefits shall continue to be paid pending an independent medical examination if one is ordered by the Claims Administrator, in its sole discretion, provided that you comply reasonably and timely with the Claims Administrator's order. During such time period, you will be in an Administrative Denial. However, if following the independent medical examination, you are determined to have not been Disabled during such period, you will be required to repay any Short-Term Disability Benefits paid from the date of the Administrative Denial and to return to work or to terminate employment. The Program may recover the Administrative Denial overpayment amount by payroll deductions, or, if you are terminated, from your unused vacation and personal days, termination, severance, or any other amounts payable to you (to the extent permitted under other policies and plans), or if such amounts are not sufficient, directly from you.

Two-Day Extension in Limited Circumstances

If you are no longer Disabled, and you are released to return to work with medical restrictions, you may receive as determined by the Claims Administrator two additional days of Short-Term Disability Benefits after your Participating Company is notified if the Participating Company, in its discretion, needs more time to evaluate whether modified duty assignments are available.

Impact on Your Employment Status

Your employment is terminated after you receive 52 weeks of Short-Term Disability Benefits, unless you return to work. The termination occurs even if you are approved for Long-Term Disability Benefits.

If the Claims Administrator determines that you are no longer eligible for Short-Term Disability Benefits before you reach 52 weeks, you will be required to return to work in accordance with normal corporate policies. If you do not return to work, you will be considered a former employee and, as such, have no guarantee of reemployment with the Company.

Any absence that qualifies for Short-Term Disability Benefit payments (as well as the first seven Days of Absence due to an illness or injury that results in a Short-Term Disability Benefit payment under this Program) shall be counted against your annual leave entitlement under the Family and Medical Leave Act of 1993 (FMLA) to the extent that such entitlement is available.

YOUR LONG-TERM DISABILITY BENEFITS

KEY POINTS

A. *If you are approved to receive Long-Term Disability Benefits, your benefits will begin on the first day immediately following your 52 weeks of Short-Term Disability Benefits.*

B. *The Program pays Long-Term Disability Benefits that equal 50 percent of your Pay, reduced by the listed Offsets.*

C. *Long-Term Disability Benefits will continue for most Eligible Employees until age 65 if you remain Disabled for purposes of Long-Term Disability Benefits.*

D. *If you are receiving Long-Term Disability Benefits, your employment with the AT&T Group of Companies will be terminated.*

This Program provides Long-Term Disability Benefits to Eligible Employees who are Disabled on the first day immediately following 52 weeks of Short-Term Disability Benefits.

Excluded Employees

Term and Temporary Employees are **not** eligible for Long-Term Disability Benefits under the Program.

When You Are Considered Disabled

You are considered Disabled for purposes of Long-Term Disability Benefits under this Program when you have a continuous physical or mental illness or injury, whether work related or non-work related, that renders you unable to perform any type of work other than work for which the rate of pay is less than 50 percent of your Pay on the day immediately before your Short-Term Disability Benefits began.

- Your earnings potential will be determined using potential jobs in the community.
- The earnings test shall take into account your functional capacities, background (i. e., education, training, work experience), transferable skills, and your age.
- The geographic area searched for jobs will be within a 35-mile radius of your home address and/or your prior work location.

You may be eligible for Long-Term Disability Benefits if you are only capable of performing a job which pays less than 50 percent of your Pay before your Short-Term Disability Benefits started.

The Long-Term Disability Benefits payable when added to the gross pay you receive from working (or potential gross wages) and other sources of income or benefits listed as Offsets cannot exceed 75 percent of your Pay prior to the time your long-term disability started.

You are **not** eligible to receive Long-Term Disability Benefits if your Disability is caused or contributed to by any injury or illness sustained as a result of any of the following:

- Your committing a felony;
- Your intentionally self-inflicting an injury (whether or not you are sane or insane when inflicted);
- Military service;
- War, declared or undeclared, or any act or hazard of war occurring after you become covered under the Program; or
- Your active participation in a riot, terrorist act, insurrection, rebellion or civil commotion.

Filing for Benefits

As a general rule, shortly before you reach the end of the 52-week period during which you received Short-Term Disability Benefits under the Program, the Claims Administrator will send you the appropriate forms to apply for Long-Term Disability Benefits from the Program, as well as information on filing for Social Security Disability Insurance benefits. If you are within a few days of the end of the 52-week Short-Term Disability Benefits period and you have not received the forms for applying for Long-Term Disability Benefits from the Program, contact the Claims Administrator and ask for them to be sent. See the "Contact Information" section for information on how to contact the Claims Administrator.

In order to be considered for Long-Term Disability Benefits, you must:

- Be an Eligible Employee. See the "Eligibility for the Program" section for more information on eligibility.
- Have received the maximum amount (52 weeks) of Short-Term Disability Benefits under the Program (and all benefits payable as Short-Term Disability Benefits have been exhausted).
- Continue to be Disabled as a result of injury or illness beyond the 52-week maximum of Short-Term Disability Benefits.
- File a written application for Long-Term Disability Benefits with the Claims Administrator, with objective Medical Evidence of Disability, no later than 90 days after the end of the 52-week maximum of Short-Term Disability Benefits. See the "Contact Information" section for the mailing address of the Claims Administrator.
- Ensure that your medical providers cooperate with the Claims Administrator to provide all necessary information during the 90-day period described in this section.
- Be under the care of a physician and follow his or her recommended treatment. The Claims Administrator will require that you periodically furnish satisfactory objective Medical Evidence of your Disability from your physician. Proof of Disability must be in writing and consist of all objective Medical Evidence, psychological, educational, and vocational information that the Claims Administrator considers pertinent to your claim.
- Maintain contact with the Claims Administrator as required by the Claims Administrator unless your location or the severity of your condition prevents you from doing so.

- Report for a medical examination or testing by a physician or by any other medical or clinical provider with expertise in assessing the nature and extent of a disability as requested by the Claims Administrator, if the Claims Administrator requires this examination to initially qualify for or continue your Long-Term Disability Benefits. If your claim for Benefits is approved, the Claims Administrator may in its discretion require periodic medical updates, including medical examinations. You will not be required to pay for medical examinations requested by the Program to determine your continuing qualification for Long-Term Disability Benefits.
- Provide your physician or other medical provider a signed copy of the medical release form provided by the Claims Administrator.
- The Claims Administrator may require any person for whom a claim is pending or in progress to undergo a vocational assessment by a qualified vocational counselor. You will not be required to pay for this assessment.

Only the Claims Administrator has the discretion to determine whether you have a disability that qualifies you for Long-Term Disability Benefits under the Program. See the "Additional Information About Filing a Claim for Benefits Under the Program" section for information about filing a claim.

When Long-Term Disability Benefits Begin

Your Long-Term Disability Benefits begin on the first day immediately following the end of the 52-week period during which you received Short-Term Disability Benefits from this Program, provided that at the end of the 52-week period you are considered Disabled for purposes of Long-Term Disability Benefits.

> **Important:** If your employment with a Participating Company terminates for any reason, including but not limited to retirement or layoff, prior to the expiration of the 52-week maximum of Short-Term Disability Benefits, you will not be eligible for Long-Term Disability Benefits from the Program.

Impact on Your Employment Status

If you are approved for Long-Term Disability Benefits, your employment is terminated when you have reached your maximum Short-Term Disability Benefits unless you return to work.

✷ Special Rule for Reemployment

If you qualified for Long-Term Disability Benefits before Jan. 1, 1993, you have no guarantee of re-employment if your Disability ceases.

If you qualified for Long-Term Disability Benefits on or after Jan. 1, 1993, when your Disability ceases you will be given the same return rights as laid-off employees of your Participating Company, in accordance with the applicable collective bargaining agreement.

Amount of Long-Term Disability Benefits

The Program pays Long-Term Disability Benefits that equals 50 percent of your Pay, offset (reduced) by other sources of income listed in the "Offsets" section.

Pay

Your Pay is your monthly base Pay based on your normally scheduled hours, including evening and night differential, if applicable, as determined from the Company's payroll records immediately prior to the commencement of your Long-Term Disability Benefits. For Sales Consultants paid pursuant to a leveraged compensation plan, Pay will be based on base wages plus 100 percent of the target incentive amount, as defined under the collective bargaining agreement. For other commissioned sales representatives, Pay will be based on your average weekly earnings or the non-selling rate, whichever is applicable. Pay shall not include short-term awards, bonuses, and any other non-periodic payments. Your normally scheduled hours are those hours that you generally are scheduled to work, excluding additional special hours worked such as overtime, special projects, and training.

Offsets

Your Long-Term Disability Benefits will be offset (reduced) by amounts paid from any of the following sources of income available to you (but excluding cost-of-living increases that may occur after your first monthly Benefit is paid) taken in the following order:

- Social Security Disability Insurance Benefits (SSDIB) and/or old-age benefits under the Social Security Act. Only the primary benefit amount will be taken into account. You are required to apply for benefits under the Social Security Act. If you have not applied for SSDIB, then your Long-Term Disability Benefits will be offset (reduced) by an estimated SSDIB amount until application for SSDIB has been made. The SSDIB application procedure will be provided with the Long-Term Disability application. Proof of application for SSDIB may be provided when applying for Long-Term Disability Benefits. If such proof is provided along with a signed agreement obligating you to repay any Long-Term Disability Benefits overpayment if SSDIB is awarded (including an automatic debit agreement), the SSDIB Offset will be waived. If such repayment agreement is not honored, the Participating Company has and reserves the right to deduct the amount of overpayment from future Long-Term Disability Benefits payments.

  You are required to appeal any denial of your Social Security benefit. If you fail to make an appeal, your Long-Term Disability Benefits will be offset (reduced) by an estimated SSDIB amount. You must advise the Claims Administrator of the final Social Security award or denial as soon as you receive it; then the monthly benefit paid will be recalculated to determine the amount of monthly benefit which would have been paid had the Social Security decision been known when the monthly benefit was being paid. If the monthly benefit paid was:

  - Less than it should have been, you will be paid the difference, with interest;
  - More than it should have been, you will be billed the difference.

  When you reach age 62, your Long-Term Disability Benefits will be reduced by the amount of your Social Security old age insurance benefits, whether or not you apply, unless your Long-Term Disability Benefits are already offset by SSDIB which started at an earlier age.

Your Long-Term Disability Benefits will not be reduced by any cost-of-living adjustments to any Offsets after your first Long-Term Disability Benefit payment. Future benefits under the Social Security Act will be used to offset your Long-Term Disability Benefits.

- Benefits from the Southeast Program of the AT&T Pension Benefit Plan (including both qualified and non-qualified payments for disability, service, or deferred vested pension) whether paid in a monthly annuity or lump sum or rolled-over amount. Your Program benefits will be reduced in the amount equal to the amount payable to you as a monthly single life annuity, whether or not you actually elect this form of payment. For example, if you elect a lump sum cash-out to be paid to you in cash or roll it over into a traditional individual retirement account (IRA) or an Eligible Retirement Plan (as defined by the Internal Revenue Code), the equivalent monthly single life annuity amount will be calculated and your Long-Term Disability Benefits will be reduced by that amount each month. Once the amount of your pension benefit is determined and paid, any increase in your pension benefit will not decrease the amount of your Long-Term Disability Benefits. Your Long-Term Disability Benefits will only be offset by Southeast Program of the AT&T Pension Benefit Plan benefits if your pension plan benefits actually commence.

- Workers' Compensation Benefits. If you are unable to work as a result of a work-related disability, you may be eligible to receive Workers' Compensation Benefits. Workers' Compensation Benefits, including permanent disability, will reduce your Long-Term Disability Benefits. Any Workers' Compensation or similar law benefits paid as a lump sum will be considered to be paid in monthly amounts over the period of time covered by the lump sum payment. If the period of time is not specified, a five-year period or such other period as may be determined by the Plan Administrator, will be used to calculate the Offset.

- State Disability Insurance (SDI) and other benefits of the same character under any state or federal disability law, such as benefits under disability insurance laws of any other state, or the functional equivalent of Workers' Compensation Benefits except veterans' benefits. You must pursue any applicable appeals if your claim is denied. The Plan Administrator has the sole discretion to determine what payments under current or future laws are of the same general character as benefits under the Program.

For any Offset amounts which are paid on any basis other than monthly (excluding Workers' Compensation or similar law benefits and pension payments from the Southeast Program of the AT&T Pension Benefit Plan), the Plan Administrator will determine the monthly equivalent of that payment to be used as an Offset to the Long-Term Disability Benefits. Any such benefits (Offsets) paid in a lump sum will be considered as paid in monthly amounts over the period of time covered by the lump sum payment. Any lump sum payments from any of the above Offset sources will be considered as an Offset of Disability payments unless you give the Claims Administrator satisfactory proof to the contrary.

This means that if the amount you receive from the Offsets listed on the previous page is less than 50 percent of your Pay, Long-Term Disability Benefits provide additional payments to bring your total disability income up to that level. If your combined income from Offsets is equal to or greater than 50 percent of your Pay, you will not receive payments from the Program. The Program may seek to recover any overpayments that you receive.

Example: If you receive Workers' Compensation Benefits or a settlement of those benefits while, or after you have been receiving Long-Term Disability Benefits from this Program, your future Long-Term Disability Benefits will be reduced to reflect the amount of the payment. In some cases, the Claims Administrator may determine that you have received an overpayment for which repayment to the Program will be necessary.

There is no time limit on when Offsets can be applied. Failure to apply an Offset as soon as it is available will not constitute a waiver by the Program of offset rights or otherwise prevent their later exercise.

Important: No Long-Term Disability Benefits payable under the Program will be reduced by reason of any veterans' benefits.

How Benefits Are Paid

Any Long-Term Disability Benefits you receive will be payable on the last day of each month. Any payment due for a period of time that is less than one month will be prorated based on the number of days for which Long-Term Disability Benefits are payable. Additionally, under current law, the Long-Term Disability Benefits are considered federal taxable income.

If you have income from a job you are performing while you continue to qualify for Long-Term Disability Benefits, your Long-Term Disability Benefit amount will be adjusted as described in the "When You Are Considered Disabled" section.

Except when you receive a partial month payment (as described in the "How Benefits Are Paid" section) or are working Disabled (as described in the "When You are Considered Disabled" section), you are not entitled to receive Long-Term Disability Benefits for any period of time during which wages are paid to you by a Participating Company or an affiliated company or a company which has entered into an arrangement for an interchange of benefits obligations.

Conversion to Lump Sum

If your Long-Term Disability Benefits are initially approved for an injury or illness from which you are expected to die within 12 months, you may request payment in a lump sum representing the present value of the Long-Term Disability Benefits that you would receive based on your life expectancy (not to exceed 12 months). Your request should be made according to the appeal procedures of this Program. If you receive a lump sum settlement under this section, you shall not in any event be eligible for any additional benefits from the Program. See the "How to File an Appeal" section for more information.

When Your Long-Term Disability Benefits End

Your Long-Term Disability Benefits end when the first of the following events occur:

- You cease to be Disabled for purposes of Long-Term Disability Benefits, as determined by the Claims Administrator in its discretion;
- You die;
- You are not under the continuous care of a physician or you are not receiving treatment considered reasonable by the Claims Administrator;
- You fail to furnish objective Medical Evidence of the continuance of Disability when requested by the Claims Administrator or you fail to submit to an examination requested by the Claims Administrator;
- Your current gross wages plus Long-Term Disability Benefits and Offset amounts set forth under the subsection entitled "Amount of Long-Term Disability Benefits" equal or exceed 75 percent of your pre-Long-Term Disability Pay;
- You reach age 65 (if you begin receiving Long-Term Disability Benefits before age 60) or the date that is five (5) years following your commencement of benefits (if benefits commenced under the Long-Term Disability Benefits after you reached age 60); or
- You return to work with any of the AT&T Group of Companies.

Successive Periods of Long-Term Disability

If your Long-Term Disability Benefits cease because you cease to be Disabled and you are rehired by a Participating Company, your Long-Term Disability Benefits will continue if you become Disabled within 26 consecutive weeks of the date you ceased to be Disabled. Your second period of Disability will be considered a continuation of the prior Disability (regardless of whether the second Disability results from a different illness or injury) using the Pay applicable as of the first day of the most recent period of Disability, subject to any increases or decreases in the Offset amounts. You will not be eligible for a new 52 weeks of Short-Term Disability Benefits for the second period of Disability.

FINAL UNPAID BENEFITS UNDER THE PROGRAM

If you die, any unpaid benefits under the Program may be paid through the date of your death, at the discretion of the Claims Administrator and if permitted under local law, to your spouse or domestic partner (as recognized under AT&T Southeast's domestic partner policy), provided that such person did not willfully contribute to your death. If you have no spouse or domestic partner, these benefits will be paid to your estate.

BENEFITS PROVIDED UNDER OTHER PLANS OR PROGRAMS

For eligibility regarding other health and life insurance benefits you may be eligible for while receiving benefits under the Program, refer to the SPD that governs eligibility for the applicable benefit plan.

ADDITIONAL INFORMATION ABOUT FILING A CLAIM FOR BENEFITS UNDER THE PROGRAM

KEY POINT

A. Generally, you will receive a written notice within 45 days from the Claims Administrator if your claim for benefits is approved or denied.

When you make a claim for benefits under the Program, the Program's Claims Administrator will notify you of the decision regarding your claim within 45 days of the date your claim is received by the Claims Administrator. The Claims Administrator may extend this 45-day period for up to 30 days (plus an additional 30 days if needed) if it determines that special circumstances outside of the Program's control require more time to determine your claim.

You will be notified within the initial 45-day period (and within the first 30-day extension period if an additional 30 days are needed) whether additional time is needed and what special circumstances require the extra time. If extensions are required because the Claims Administrator needs additional information from you, you will have 45 days from the Claims Administrator's 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. If you do not receive a written response within the time limits described in this paragraph, your claim will be deemed denied and you will have the right to file an appeal.

If you receive a written or electronic notice from the Claims Administrator that your claim is denied, the notice will contain:

- Specific reasons for the denial.
- Specific reference to the Program provisions, or applicable law, on which the denial is based, where applicable.
- 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.
- An explanation of the scientific or clinical judgment for the determination and how the terms of the Program were applied to your medical circumstances if the determination is based on medical necessity, experimental treatment or a similar exclusion or limit and that a copy of the explanation will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your claim acceptable and the reason the information is needed.
- A description of the procedure by which you may appeal the denial to the Program's Claims Administrator.
- A statement concerning your right to file a civil action under ERISA after the required review and all appeals have been completed.

Important: As a requirement for receiving benefits from the Program, you must authorize AT&T or any Participating Company or any provider of documentation of a claim to furnish the Claims Administrator with any and all information and records relating to your claim. Such authorization will be treated as a waiver of all provisions of law forbidding such disclosure.

HOW TO APPEAL A DENIAL OF BENEFITS UNDER THE PROGRAM

KEY POINTS

A. You have 180 days after receipt of the denial notice to submit a written request to appeal the decision.

B. Generally, you will receive a final determination regarding your appeal within 45 days of receipt of your appeal by the Claims Administrator.

C. You may not file a lawsuit against the Plan until you complete the appeal process.

When You May File an Appeal

If your claim is denied in whole or in part (or you have **not** received a decision or a notice of extension within the applicable period) and you disagree with the decision, you may appeal the decision by filing a written request for review. You or your authorized representative must make the request for review within 180 days of receipt of the denial notice (or within 180 days after the review period has expired).

Who Decides Your Appeal

The Plan Administrator has delegated discretion and authority to decide appeals to the Claims Administrator. See the "Contact Information" section for information on how to contact the Claims Administrator. The Claims Administrator will have full and exclusive authority and discretion to grant and deny appeals under the Program. The decision of the Claims Administrator regarding any appeal will be final and conclusive.

How to File an Appeal

If you or your authorized representative sends a written request for review of a denied claim, you or your representative have the right to:

- 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. See the "Contact Information" section for the mailing address of the Claims Administrator.
- Upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits provided that the Claims Administrator finds that the requested documents or material are pertinent to your appeal and are required to be disclosed by ERISA.

- 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.

In your appeal, you should state as clearly and specifically as possible any facts and/or reasons why you believe the Claims Administrator's action is incorrect. You should also include any new or additional evidence or materials in support of your appeal that you wish the Claims Administrator to consider. Such evidence or material must be submitted along with your written statement at the time you file your appeal.

One or more qualified individual(s) who was not involved in the decision to deny your initial claim will be appointed to decide the appeal. This individual will decide the appeal based upon the evidence that was considered by the Claims Administrator; the issues, records and comments submitted by you; and such other evidence as the individual may independently discover.

If your claim was denied based upon medical judgment, the review will be done in consultation with a health care professional with appropriate expertise in the field and who was not involved in the initial determination. The Claims Administrator may consult with, or seek the participation of, medical experts either employed by or retained by the Claims Administrator as part of the appeal resolution process. When you file your appeal, you consent to this referral and the sharing of pertinent information.

Your appeal may be decided entirely on the basis of evidence submitted in writing, and you are not entitled to a hearing, nor do you have the right to present oral testimony or cross-examine authors of written evidence submitted. You will be provided with the identity of any medical or vocational experts whose advice was obtained by the Program in connection with denial of your appeal, without regard to whether the advice was relied upon in making the benefit determination.

Unless you are notified in writing that more time is needed, a review and decision on your appeal must be made within 45 days after your appeal is received. If special circumstances require more time to consider your appeal, the Claims Administrator may take an additional 45 days to reach a decision, but you must be notified in writing that there will be a delay prior to the end of the initial period, the reason for the delay, and the date by which a decision will be made. If the decision of the Claims Administrator is not furnished within the time specified above, the appeal will be deemed to have been denied.

If your appeal is denied in whole or in part, the Claims Administrator's decision will be in writing or sent electronically and will contain:

- Specific reasons for the denial.
- Specific references to the Program provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the determination, a statement that such rule, guideline, protocol or criterion was relied on in making the determination and a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- An explanation of the scientific or clinical judgment for the determination and how the terms of the Program were applied to your medical circumstances if the determination is

based on medical necessity, experimental treatment or a similar exclusion or limit and that a copy of the explanation will be provided free of charge upon request.

- A description of any additional material or information required for payment of benefits under the Program.
- A statement concerning your right to file a civil action under ERISA.

How to File a Second Appeal for Short-Term Disability Benefits

If your appeal for Short-Term Disability Benefits is denied, you or your authorized representative has the right to send a written request for review of a denied appeal. The procedure, requirements, and timeframes to submit a second appeal are the same as above in the "How to File an Appeal" section. One or more qualified individual(s) who was not involved in the decision to deny your initial appeal will be appointed to decide the second appeal.

If your second appeal is denied, it is final and not subject to further review unless a court of competent jurisdiction determines that the Claims Administrator has abused its discretion in deciding to deny the claim.

Importance of Exhausting Administrative Remedies

If your final appeal is denied, it is not subject to further review unless a court of competent jurisdiction determines that the Claims Administrator has abused its discretion in deciding to deny the claim.

If you wish to bring a legal action concerning your right to participate in the Program or your right to receive benefits under the Program, you must first go through the applicable claims and appeal process described in this section including both levels of appeal for Short-Term Disability Benefits. A legal action may not be filed until you have completed the claim and appeal process. Legal action involving the Program should be filed against the AT&T Umbrella Benefit Plan No. 1.

Any legal action based on a denial of eligibility and/or for benefits under the Program must be filed no later than 180 days after the date of the final denial by the Claims Administrator.

Release of Information

When you file a claim, the Claims Administrator will forward a medical release form to you which will allow the Claims Administrator to request and obtain from, or release to, any person any information deemed necessary by the Claims Administrator to process or verify your claim. If the medical release form is not completed and returned to the Claims Administrator in a timely manner, benefits under the Program may be delayed or denied.

OVERPAYMENTS

The Program has the right to collect (at any time) any overpayment made to you by withholding your benefit payments from this Program, by deducting it from future wages, by seeking it from any organization or person to, for or with respect to whom such payment was made (including your estate), or by any other means, including bringing a civil action in court. Any overpayment by the Program may be recovered by withholding any benefit payable by the Program (for example, an overpayment while you are receiving Short-Term Disability Benefits may result in a reduction in your Long-Term Disability Benefits from the Program). If such amount is not paid immediately, you or your representatives or estate will be responsible for payment with interest and any attorneys'

fees involved in collecting the amount due. If you (or your attorney or other representative) receive any funds that qualify as Offsets, you agree to place the funds in a separate, identifiable account. You also agree that the Program has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Program has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

ERISA RIGHTS OF PARTICIPANTS

KEY POINTS

A. ERISA is a federal law that provides certain rights and protection to all Program Participants.

B. The persons who are responsible for the operation of the Program have a duty to act prudently and in the interest of all of the Participants and their beneficiaries.

C. No one may fire or discriminate against you for exercising your ERISA rights.

As a Participant in the Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you, and all other Participants, shall be entitled to:

Receive Information About Your Plan and Benefits

You can:

- Review at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Program, insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Association. There is no charge for this review.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Program, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. If you wish to request copies of any of these documents send your request in writing to the following address:

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

- Receive a summary of the Program's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each Participant with a copy of any required summary annual report (SAR).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Program Participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Program, called "fiduciaries" of the Program, have a duty to do so prudently and in the interest of you and other Program Participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Program benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the Program and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance With Your Questions

If you have any questions about your Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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

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

DEFINITIONS

AT&T or **Company**. AT&T Inc., a Delaware corporation, or its successors.

AT&T Group of Companies. AT&T Inc. and any other entity included with it as an "employer" as determined pursuant to Internal Revenue Code §414(b), (c), (m) and (o) and the regulations thereto.

Bargained Employee. This refers to any employee whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union that has agreed to the benefits provided under the Program.

Claims Administrator. The individual or entity delegated by the Plan Administrator to determine all claims and appeals for benefits under the Program. Currently, the Claims Administrator is Sedgwick Claims Management Services, Inc., which operates the AT&T Integrated Disability Service Center. See the "Contact Information" section for information on how to contact the AT&T Integrated Disability Service Center.

Day of Absence. A full day of absence, based on your normal daily schedule, on which you were expected or scheduled to report for duty but could not do so because of illness or injury. Day of Absence does not mean any scheduled absence, such as a vacation day, optional holiday, excused work day, period of departmental leave, or period of suspension. However, with respect to vacation, you may request, on or before the first day of any full week of vacation, to reschedule vacation if you would otherwise be unable to report for duty because of illness or injury. If this occurs, your first Day of Absence is the first day of the vacation week that was rescheduled. If you are on a departmental leave at the onset of an illness or injury, your first Day of Absence is the day you were scheduled to work following the departmental leave but were unable to do so because of illness or injury.

Leased Employee. A Leased Employee is an individual who is being paid by a company other than one of the AT&T Group of Companies and who is providing services to one or more of the AT&T Group of Companies in accordance with a contract that is between the company that is paying him and one or more of the AT&T Group of Companies. A Leased Employee is not eligible for coverage under the Program even if he is considered to be a "common law employee" of one of the AT&T Group of Companies.

Leave of Absence. Leave of Absence means a leave of absence formally granted to an employee in accordance with rules established by his Participating Company.

Long-Term Disability Benefits. Long-Term Disability Benefits that are provided under the Program. See the "Your Long-Term Disability Benefits" section.

Medical Evidence. Objective medical information sufficient to show that the participant is Disabled, as determined in the sole discretion of the Claims Administrator. Objective medical information includes, but is not limited to, results from diagnostic tools and examinations performed in accordance with the generally accepted principles of the health care profession. In general, a diagnosis that is based largely or entirely on self-reported symptoms will not be considered sufficient to support a finding of Disability. For example, reports of intense pain, standing alone, will be unlikely to support a finding of Disability, but reports of intense pain associated with an observable medical condition that typically produces intense pain could be sufficient.

Occasional Employee. You are an Occasional Employee if you are engaged by a Participating Company on a daily basis for a period of not more than three consecutive weeks, or for a cumulative total of not more than 30 days in any calendar year, regardless of the length of the daily or weekly assignments, or as otherwise defined in the collective bargaining agreement applicable to you. Occasional Employees are **not** eligible for the Program.

Participant. An Eligible Employee or former employee who is receiving benefits under the Program.

Primary Social Security Benefits. The Primary Insurance Amount payable to the employee on account of disability in accordance with the United States Social Security Act that covers any portion of the period for which benefits are paid under the Program, and are payable on account of the employee's disability.

> **Important:** You and your Participating Company both pay Social Security taxes to provide benefits at retirement or if you become Disabled. If you qualify, you may receive Social Security Disability Insurance Benefits in addition to the Disability benefits under the Program. These benefits are not paid automatically, so you must apply for them in all cases.

Regular Employee. You are a Regular Employee if your employment with a Participating Company is expected to be indefinite, as determined by your Participating Company, or as otherwise defined in the collective bargaining agreement applicable to you.

Short-Term Disability Benefits. Short-Term Disability Benefits that are provided under the Program. See the "Your Short-Term Disability Benefits" section.

Temporary Employee. You are a Temporary Employee if you are in a position designated as "Temporary" by your Participating Company pursuant to the terms of the collective bargaining agreement applicable to you.

Term Employee. You are a Term Employee if you are in a position designated as "Term" by your Participating Company pursuant to the terms of the collective bargaining agreement applicable to you.

Trust. The Code Section 501(c)(9) Voluntary Employee Beneficiary Association (VEBA) trust which provides funding for the Program and which was established under the Internal Revenue Code of 1986, as amended.

Workers' Compensation Benefits. Workers' Compensation Benefits means all classes of benefits under the workers' compensation laws of any state, the District of Columbia, the United States government (e.g., benefits under the Longshore and Harbor Workers' Compensation Act) or any other jurisdiction in any country that requires payments to employees on a temporary or permanent basis in connection with injuries arising out of or in the course of employment, to replace or supplement income, or to compensate for diminished ability to compete in an open labor market, including but not limited to payments for temporary partial disability, temporary total disability, permanent partial disability, permanent total disability, vocational rehabilitation maintenance allowance and disability pension, whether liability for such payment has been determined by the court or administrative agency that determines liability for workers' compensation under the laws of such jurisdiction, or accepted voluntarily by the Participating Company or the Participating Company workers' compensation administrator or insurer.

PLAN ADMINISTRATION

Plan Information	
Plan Name	AT&T Umbrella Benefit Plan No. 1
Program Name	AT&T Southeast Disability Benefits Program
Plan Sponsor	AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160
Plan Administrator	AT&T Services, Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Employer Identification Number	43-1301883
Plan Number	600
Type of Plan	Employee Welfare Plan – Disability
Plan Year	Jan. 1 through Dec. 31
Agent for Service of Legal Process	AT&T Services, Inc. P.O. Box 132160 Dallas, TX 75313-2160 Service may also be made upon a Plan Trustee or the Plan Administrator.
Program Funding	The Program is funded by a trust. Program costs are funded by periodic, non-reversionary Participating Company contributions determined by the Program's actuaries for the purpose of funding Program benefits and maintaining appropriate reserves. Contributions are transferred to the Trust, which is established exclusively for approved Plan purposes. Benefits under the Program are paid or reimbursed by the Trust. Benefits paid in excess of IRS limits are funded by the general assets of your Participating Company. No benefits provided under the Program are provided by insurance.
Plan Trustee	Frost National Bank P.O. Box 2950 San Antonio, TX 78299
Collectively Bargained Plan	With respect to certain Eligible Employees, the Program is maintained pursuant to one or more collective bargaining agreements. Copies of the collective bargaining agreements may be obtained by employees whose rights are governed by such collectively bargained agreement upon written request to the Plan Administrator. See the "Receive Information about Your Plan and Benefits" section for contact information.

Table continued on next page.

Plan Information	
Type of Administration	The Plan Administrator determines eligibility for coverage under the Program, that is, whether any particular individual is included in a group of employees that is covered by the Program. The Claims Administrator has been delegated the complete discretionary fiduciary responsibility for all disability determinations by the Plan Administrator to determine whether a particular Eligible Employee who has filed a claim for benefits is entitled to benefits under the Program, to determine whether a claim was properly decided, and to conclusively interpret the terms and provisions of the Program. Such determinations and interpretations shall be final and conclusive. The Plan Administrator (or, in matters delegated to third parties, the third-party that has been so delegated) will have sole discretion to interpret the Program, including, but not limited, to interpretation of the terms of the Program, determinations of coverage and eligibility for benefits, and determination of all relevant factual matters. Any determination made by the Plan Administrator or any delegated third party will not be overturned unless it is determined to be arbitrary and capricious.

Amendment or Termination of the Program

The Program is adopted with the intention that it will be continued for the benefit of present and future employees of Participating Companies; however, the right is reserved by the Plan Sponsor to terminate, amend, change or modify the Program retroactively or prospectively, in whole or in part at any time or for any reason, including changes in any and all of the benefits herein provided. Further, any Participating Company may terminate its participation in the Program at any time and for any reason. Such termination, amendment, change or modification of the Program, or termination of any Participating Company's participation in the Program may cause employees to lose all or a portion of their benefits or eligibility under the Program, but will not affect the right of any employee to receive benefits for which he has already become entitled under the Program. Not affecting an employee's right to any benefit for which he has already become entitled under the Program means that an employee who is actually receiving payments would be entitled to continue receiving his disability benefits through the date of the Program's termination or change, unless the employee consents, until such benefits would otherwise cease. This does not mean that an employee will acquire a lifetime right to any Program benefit, to eligibility for coverage under the Program or to the continuation of the Program merely by reason of the fact that such benefit or the Program is in existence at any time during the employee's employment. The Program will comply with all requirements of applicable law and will be amended, if necessary, in order to satisfy any such requirements.

In the event of termination of the Program, you will be entitled to the benefits in effect at the time of any event that requires payment of such benefits. Although a certain Plan or one of its Programs may be in effect during your employment or at the time of your retirement, it does not mean that you or any other employee or beneficiary will have:

- A lifetime right to any benefits under the Plan or Program.
- Eligibility for coverage under any such Plan or Program.
- Guaranteed continuation of any such Plan or Program.
- Coverage at Company expense or based upon a previously identified contribution schedule.

Limitations on Rights

Participation in the Program does not give you the right to remain employed at any AT&T company.

Applicable Law

The Program shall be construed and administered in accordance with the laws of Georgia unless preempted by federal law.

Assignment and Nonalienation

Except as otherwise required by law, benefits provided under the Program may not be assigned or alienated. This means that you may not sell, assign, pledge or otherwise transfer benefits under the Program before the benefits are distributed to you, nor are your Program benefits subject to attachment, garnishment, execution or encumbrance of any kind prior to distribution to you.

Withholding of Taxes

A Participating Company or trustee may withhold from any payment of benefits under the Program an amount it deems sufficient to cover required withholding taxes. A Participating Company shall have the right to require that any person furnish information deemed necessary by it to meet any tax withholding or reporting obligation before making any payment under the Program.

Benefit Payment Checks

Benefit payment checks that are not cashed within 120 days after the date of the check will be considered null and void, and the benefit so paid will be forfeited. Any benefit so forfeited may be reinstated by filing a claim for the forfeited amount within 12 months of the date the check was originally issued and satisfactorily documenting entitlement to the payment.

CONTACT INFORMATION

To initiate a claim for benefits under the Program, call the AT&T Integrated Disability Service Center.

☎ **866-276-2278**

Monday through Friday from 7 a.m. to 7 p.m. Central time

Written claims for benefits under the Program may be sent to:

AT&T Integrated Disability Service Center
P.O. Box 14627
Lexington, KY 40512-4627

866-224-4627

To initiate an appeal of a denied claim for benefits under the Program, send a written appeal to the AT&T Integrated Disability Service Center.

The AT&T Integrated Disability Service Center
Quality Review Unit
P.O. Box 14626
Lexington, KY 40512-4626

866-856-5065

INFORMATION CHANGES AND OTHER COMMON RESOURCES

It's important to keep your work and home addresses current because the majority of your benefits, payroll or similar information is sent to them. Please include any room, cubicle or suite number that will help make mail-routing more efficient.

Active Employee Address and Telephone Number Changes
For employees with access to the employee intranet: **Home** and **Work** address updates: • Go to **insider.web.att.com**. • Click on HROneStop **(hronestop.att.com)** and select eLink (eCORP) in the right navigation bar. • Enter your AT&T User ID and password for the AT&T Global Logon. (If you do not know your password, please follow the instructions on the screen.) • Once logged on, click OK. • 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 Personal Information. • Select Maintain Addresses and Phone Numbers. • To update your home address, select Edit at the bottom of the Permanent Residence box, make any necessary changes, and click Save. • To update your work address, select Edit at the bottom of the Cubicle/Office 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 Benefits section of HROneStop (active employees only) Go to the Your Benefits section of HROneStop at **hronestop.att.com.** This site provides access to administrator Web sites, which may include provider directories, summary plan descriptions (SPDs) and other tools, and selected current communications.
Your Benefits section of access.att.com (employees and retirees from home) Go to the Your Benefits section of **access.att.com** (AT&T's secure Internet site) for benefits information at home. Just go to **access.att.com** and follow the login instructions.

Retired and Inactive Employee Home Address Changes

You must change your address for both pension and savings. To change your address for both purposes, contact both the AT&T Benefits Center (pension) and the Fidelity Service Center (savings).

AT&T Benefits Center
P.O. Box 785038
Orlando, FL 32878-5038

→ **resources.hewitt.com/att**

☎ **877-722-0020**

☎ **847-883-0866** (international)

847-883-9145

Monday through Friday from 9 a.m. to 5 p.m. Eastern time

An interactive voice response system is available 24 hours a day (except Sunday 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)

> **Important:** To access the Web site, you will need your AT&T Benefits Center user ID and password. To access the AT&T Benefits Center via the 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.

Fidelity Service Center

☎ **800-416-2363**

☎ Dial your country's toll-free AT&T Direct Access number, and then enter **800-416-2363** (international).

☎ **888-343-0860** (hearing-impaired)

Monday through Friday from 7:30 a.m. to 11 p.m. Central time

You will need your Fidelity Service Center PIN and Social Security number/Customer ID to speak to a service associate.

> **Important:** These instructions are also for recipients of Long-Term Disability Benefits, employees on a Leave of Absence, as well as COBRA participants, alternate payees and survivors who have a pension benefit (including a retiree death benefit) or savings plan benefit that has yet to be paid to you.
>
> If you are not eligible to receive a pension or savings plan benefit or have already received your entire pension and savings plan benefits in a lump sum and are not eligible for a retiree death benefit from your pension plan, call the AT&T Benefits Center at **877-722-0020** to update your home address.