Midyear Enrollment 2013

February 2013
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This year you have the opportunity to make changes to your benefits during a midyear enrollment period.

Read the benefits information and reminders in this guide and decide whether to make changes for the remainder of 2013.

Your midyear enrollment period is from **March 1 – March 8**, and all changes will go into effect on **April 1.**

Be sure to read this information carefully and share it with your family so that your benefit elections support your current needs.

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

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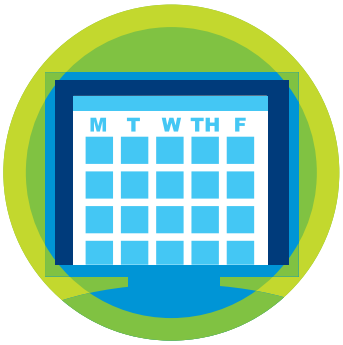

Your Midyear Benefits Enrollment Opportunity

This midyear enrollment opportunity is your chance to review your benefit options and make enrollment decisions that will be effective April 1. The information you'll need is available on the AT&T Benefits Center website. Log on to **resources.hewitt.com/att** and click on the "AT&T Benefits Center" link under "My Quick Links" on the right-hand side of the home page.

This brochure provides important information about the benefits available to you. Review your options and choose what's right for you and your family.

Your enrollment period begins at 7 a.m. on March 1 and ends on March 8 at 7 p.m. Central time.

Your Enrollment Action Items

Important Note About Flexible Spending Accounts

Changes to any flexible spending accounts (FSAs) during this enrollment period are not allowed. Any election you made effective Jan. 1, 2013, will continue through the end of the year or until you experience a qualified change-in-status event that would allow you to change your FSA election.

To help you make the right enrollment decisions for you and your family, be sure to:

Review your benefits information and know your enrollment deadline.

Evaluate your available coverage options because they have changed.

Review your benefit costs including monthly contributions, annual deductibles, out-of-pocket maximums and copayments/coinsurance for your benefit plans because they also may have changed for the remainder of 2013.

Check your medical coverage status, which could be network or outside-network-area (ONA) depending on your home ZIP code. This status can change from year to year based on changes in the provider network.

Check your supplemental life insurance smoker/non-smoker designation, which will affect the rates you pay. If you are a non-smoker and do not make a non-smoker designation, you will pay the higher smoker rates.

Review your health plan comparison charts on the AT&T Benefits Center website to compare costs and see detailed information about many of your benefits including medical, prescription drug, dental and more. These charts will have updated plan details and cost information, which may have changed from the previous year.

Review your Summary Plan Descriptions (SPDs) and Summaries of Material Modifications (SMMs). These documents provide important information on your benefit plans and programs including eligibility requirements. To view them, log on to **resources.hewitt.com/att.** Click on "Summary Plan Descriptions" under "My Quick Links" on the right-hand side of the home page.

Go Mobile With the AT&T Benefits Center

Remember, you can review, change and confirm coverage by logging on to the AT&T Benefits Center website from your mobile device.

Visit **resources.hewitt.com/att** and click on the "AT&T Benefits Center" link under "My Quick Links" to review your benefits information.

If you have a qualified change-in-status event (such as a marriage or birth of a child) that requires you to change your coverage between now and April 1, you must go to the AT&T Benefits Center website and make **two separate elections**. First, change your current coverage. Next, update your elections for the remainder of 2013. For a full list of qualified change-in-status events, refer to your SPD.

Check Your Secure Participant Mailbox If you have a preferred email address on file with the AT&T Benefits Center, your enrollment confirmation statement will be emailed to your secure participant mailbox on the AT&T Benefits Center website. You will receive an email with a link to the mailbox whenever a message is sent. If you don't currently have an email address on file, you can add one at any time on the AT&T Benefits Center website. Just click on "Your Profile" at the top of any page, then click on "Personal Information" and follow the instructions.

Use Your Tools and Resources

Visit the tools and resources section of the AT&T Benefits Center website for links to network provider directories, a medical expense estimator and more. Your benefits administrators also provide information on their websites to help you estimate costs and make informed enrollment decisions. And don't forget these helpful websites:

- *Your Health Matters* section of OneStop | onestop.web.att.com Visit this site for information about the health benefits at AT&T, links to benefit administrators and more.
- Medical Treatment Cost Estimator | myuhc.com. If you are enrolled in a company self-funded medical plan option with UnitedHealthcare as the benefits administrator, visit the **myuhc.com** home page and click on the "Estimate Health Care Costs" tab to learn about the costs associated with medical procedures and treatments you may be considering.

Family Essentials: Reviewing Dependent Eligibility

Enrollment Tip

When you go online to enroll, **be sure to have your dependents' Social Security numbers handy**. You'll need to enter them if they are not already on file with the AT&T Benefits Center.

Adding or Removing a Dependent From Coverage

Making changes to your dependent coverage is easy. Simply follow the online directions to enroll dependents or remove those who are no longer eligible.

Proof of Eligibility for Dependents You must provide proof of eligibility when adding a dependent to your coverage. Even if you simply add new or different plans for currently enrolled and approved dependents, you may still be required to provide proof of eligibility.

Newborn or Newly Adopted Child Visit the AT&T Benefits Center website within 31 days of birth or placement (60 for medical coverage) to enroll your child as a dependent and have coverage begin on your child's birthday or placement date. If you wait more than 31 or 60 days (as applicable), you must wait until the next annual enrollment or a later qualified change-in-status event to start your child's coverage. In either case, coverage cannot begin unless you supply the required proof of eligibility by the specified due date. You don't need your child's Social Security number at the time you enroll. Once you receive the Social Security card, contact the AT&T Benefits Center to update the eligibility information on file.

Removing Ineligible Dependents If your dependent becomes ineligible to participate in a company-sponsored health plan, you are required to remove that person from coverage by notifying the AT&T Benefits Center.

Note: Continuing coverage for an ineligible dependent is considered benefits fraud and can result in disciplinary action up to, and including, dismissal. You also may be responsible for repaying any benefits received by the ineligible dependent. AT&T reserves the right to audit the eligibility of any dependent at any time.

Imputed Income and Legally Recognized Partners The Internal Revenue Code requires AT&T to include the cost of benefits for a legally recognized partner (LRP) and that partner's child(ren) as income to you unless they qualify as tax dependents. This means that if you elect coverage for your LRP or your LRP's child(ren), income may be imputed to you. This imputed income amount is subject to Medicare and Social Security taxes, as well as federal income tax and state income tax where applicable.

Reminder: *Enroll Eligible Dependents for Medical Coverage up to Age 26*

As a result of Health Care Reform legislation (Patient Protection and Affordable Care Act), you can enroll eligible dependents in your medical plan and CarePlus, up to the end of the month in which they turn age 26. This does not apply to dental, vision or child life insurance plans.

Important Benefits Details for the Remainder of 2013

Company Self-Funded Medical Plan: Deductibles and Out-of-Pocket Maximums

Medical and Mental Health/Substance Abuse The deductible and out-of-pocket (OOP) maximum provisions of your AT&T company self-funded medical coverage option are changing. Effective April 1, the deductible and OOP maximum amounts will change. You can find the specific amounts on the AT&T Benefits Center website, **resources.hewitt.com/att**. Also beginning April 1, prescription drug expenses will no longer be subject to the medical deductible and will have a separate OOP maximum. The expenses you paid, which accumulated toward meeting your deductibles and OOP maximums for covered health services (medical, mental health/substance abuse (MH/SA) and prescription drugs) before April 1, will be applied to the medical and MH/SA deductibles and OOP maximums of the self-funded medical coverage option that go into effect on April 1.

If you have dependents enrolled in the company self-funded medical coverage option on or after April 1, the deductible and OOP maximums will be met as follows:

Individual +1 and Family Medical Deductible:

- A covered person is eligible to receive benefits once the allowable expenses you pay for that person satisfy the applicable* individual deductible amount.
- The individual +1 or family deductible is met once any combination of covered persons' allowable expenses, which you paid, meet the applicable deductible amount.
- It is not necessary that any one individual reach the individual deductible, but no one individual may contribute more than the individual deductible amount.

*Separate deductibles apply for network and non-network expenses. Network expenses accumulate toward meeting the network deductible and non-network expenses accumulate toward meeting the non-network deductible.

Individual +1 and Family Medical OOP Maximum:

- A covered person satisfies the OOP maximum once the coinsurance dollars you pay for that person satisfy the applicable* individual OOP maximum amount.
- The individual + 1 or family OOP maximum is met once any combination of covered persons' coinsurance meets the applicable OOP maximum amount.
- It is not necessary that any one individual reach the individual OOP maximum amount, but no one individual may contribute more than the individual OOP maximum amount.

*Separate OOP maximums apply for network and non-network expenses. Network expenses accumulate toward meeting the network OOP maximum and non-network expenses accumulate toward meeting the non-network OOP maximum.

Check Your Medical Coverage Status for the Remainder of 2013

Providers Can Change During the Year Providers may move in or out of the network at any time during the year. However, if you are enrolled in network coverage, you can't change your medical enrollment outside your enrollment period unless you experience a qualified change-in-status event. Before you receive care, check with your provider and contact the claims administrator at the number on the back of your ID card to verify that your doctor is in the network.

Network or Outside-Network-Area Coverage Network providers are readily available in most areas. Because of this, most participants will have only network plan options available to them during enrollment. A small group of participants, however, live in areas that **do not** meet the requirements for availability of specific types of providers. If you live in one of these areas, you will have the option to choose outside-network-area (ONA) coverage during the enrollment period. Network or ONA coverage is offered based on your home ZIP code. Review your enrollment information and your health plan comparison charts to confirm your options.

If you are eligible for and enroll in ONA coverage, you can go to any medical provider, even if they are not in the network, and receive the network level of benefits. You also have the option of switching to network coverage at any time during the year. Network coverage will be effective the first day of the month following the month in which you requested the change to network coverage. For example, if you submit a request in May, your network coverage will be effective beginning June 1. Once you enroll in network coverage, you cannot switch back to ONA coverage until your next annual enrollment period unless you experience certain change-in-status events.

If you are considering network coverage, you should first check the list of network providers and where they are located since you may need to travel farther to receive care. Once you choose to switch to network coverage, you must always use network providers or risk paying higher costs.

Changes to Prescription Drug Coverage

Please Note:

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

Please note the following changes, effective April 1, to your prescription drug deductible, copays and OOP maximum:

- You will no longer be required to meet a deductible for this coverage.
- Your prescription drug copays are changing for the remainder of 2013. You can find the specific amounts on the AT&T Benefits Center website.
- Your OOP maximum will be separate from your medical and mental health/substance abuse (MH/SA) out-of-pocket maximum. Any prescription copayments that were paid between Jan. 1 and March 31, 2013, will not apply to the prescription drug OOP maximum. Prescription copayments that were paid between Jan. 1 and March 31, 2013, were applied to the integrated medical and MH/SA OOP maximum.

Important

Mail orders for prescription drugs cannot be canceled or returned. Federal and state laws require that returned medication must be destroyed and cannot be restocked or reshipped to you. As a result, once the prescription drug claims administrator has begun processing your mail order, the order cannot be canceled, and you are responsible for the full copayment.

If you refuse the shipment or return the medication, you are still responsible for the full copayment. If you are uncertain of your copayment amount, contact the prescription drug claims administrator by logging on to its website or calling customer service before placing your order.

If you have dependents enrolled in the company self-funded medical coverage option on or after April 1, the OOP maximum will be met as follows:

Individual +1 and Family Prescription Drug OOP Maximum

- A covered person satisfies the individual prescription drug OOP maximum once that person's network prescription drug copays satisfy the individual OOP maximum amount.
- The individual + 1 or family OOP maximum is met once any combination of the covered persons' network prescription drug copays meet the individual + 1 or family OOP maximum amount.
- It is not necessary that any one individual reach the individual OOP maximum amount, but no one individual may contribute more than the individual OOP maximum amount.

Mail Order Prescription Drug Program Effective April 1, if you take a maintenance medication, you must use the mail order program or a CVS Pharmacy after the first two fills to receive any program benefits. The CVS Caremark mail order program allows you to have up to a 90-day supply of your maintenance drugs shipped directly to your home.

You need a prescription from your doctor that is written for up to a 90-day supply, and you must complete a mail-service order form, which you can find on the Caremark website, **caremark.com**. Once you submit the form, your prescription(s) and the appropriate payment, you'll receive your prescription(s) in about two weeks. Refills are easily ordered through the Internet, the mail or by telephone.

Maintenance Drug Frequently Asked Questions

If I don't have a written 90-day prescription and I want it called in, where should my prescriber call? If you want your 90-day prescription to be mailed from the CVS Caremark mail order facility, your prescriber should contact the FastStart Program at 800-875-0867, Monday through Friday, 7 a.m. to 7 p.m. Central time. If you want to pick it up at a CVS retail pharmacy, your prescriber should call the pharmacy.

There isn't a CVS retail pharmacy near me. Can I use another pharmacy and receive medical-plan benefits for a 90-day supply? No, this exception only applies if the prescription is filled at a CVS (or Longs in Hawaii) retail pharmacy.

If I receive an incentive offer from CVS to transfer a prescription, does transferring from the CVS Caremark mail order program to a CVS retail pharmacy count? No, it does not.

Do I have to pay for my 90-day prescription when I pick it up at the CVS retail pharmacy? Yes, the total amount is due at the time of pickup.

Continued on next page

Getting Your Long-Term Prescriptions Filled at a CVS Retail Pharmacy Effective April 1, 2013

This article does not apply to those enrolled in Fully-Insured Managed Care options.

Your prescription drug program allows you to fill a maintenance prescription (up to 30 days) *twice* at a retail pharmacy in a 12-month period. A 90-day supply of maintenance (long-term) prescriptions can be filled at a CVS (Longs in Hawaii) retail pharmacy effective April 1, 2013 (some restrictions apply), or through the CVS Caremark mail order pharmacy.

You can get from a 31- to a 90-day supply of your medication for your mail service copayment at a CVS retail pharmacy. If you obtain your maintenance prescriptions at your local CVS retail pharmacy, you have four options:

1. Have your provider write a prescription for a 90-day supply and take it to your local CVS retail pharmacy as you would any other prescription.
2. Transfer your current 90-day prescription (effective April 1, 2013) to your local CVS retail pharmacy in a few steps through **caremark.com**. Here's how:
   - Go to "My Prescriptions."
   - Click on "Transfer Prescriptions," and complete the required fields on the Refill Transfer screen.
   - Verify your transfer on the Verify Order screen. If correct, click "Place Order." The Order Confirmation screen will display. Or, you can call CVS Caremark customer service at 800-378-8851.
3. Inform the pharmacist at the CVS retail pharmacy that you would like to have your current 90-day prescription transferred from mail order. The pharmacist can initiate the transfer for you.
4. Or, direct the CVS retail pharmacist to contact your prescriber for you to get a 90-day prescription. If the pharmacist cannot reach the provider immediately, you may have to return at another time to pick up your prescription.

Note: Transferred prescriptions can generally be picked up the next day at the CVS retail pharmacy.

Maintenance Drug Frequently Asked Questions

Can I transfer my 90-day retail prescription to CVS Caremark mail order? Yes, just contact CVS Caremark customer service at 800-378-8851. Please allow standard mail order processing time.

If I already have a 90-day prescription on file either with CVS Caremark mail order or a CVS retail pharmacy, why does it have to be transferred at all? Pharmacy regulations require prescriptions to be transferred to the dispensing pharmacy, even if it is part of the same pharmacy chain. This applies to a prescription transferred from one local CVS to another local CVS, as well as from mail order to a local CVS.

I take a specialty medication. Can I now get a 90-day prescription for it at a CVS retail pharmacy? Specialty medications are not part of the maintenance prescription program. You can, however, have your specialty medication sent to a local CVS retail pharmacy for pickup. The pharmacy will let you know when it arrives and the time frame for picking it up. If you fail to do so during the specified time frame, you will still be charged the applicable copayment amount. Please ensure the specialty pharmacy has your correct phone number.

MAINTENANCE MEDICATIONS AND SPECIALTY PHARMACY			
Any Retail Pharmacy *up to a 30-day supply*	**CVS Retail Pharmacy *31- to 90-day supply***	**CVS Caremark Mail Order *up to a 90-day supply***	**Specialty Pharmacy**
Retail Copayment*	Mail Order Copayment	Mail Order Copayment	Mail Order Copayment**

*You may fill an up to 30-day maintenance prescription only twice in a 12-month period at a retail pharmacy.
**For specialty medications, you must use the specialty pharmacy program.

Note: This arrangement for filling long-term prescriptions at CVS retail pharmacies is solely at AT&T's discretion and can be terminated or modified at any point.

CVS Caremark Prescription Drug Deadlines

Your prescription drug copayment and out-of-pocket amounts will change beginning April 1, 2013. For the Jan. 1 through March 31, 2013, amounts to apply, participants must submit eligible prescription drug orders or refills according to the following guidelines:

Mail Order / FastStart CVS Caremark must receive mail orders for new prescriptions or refills by 11 a.m. Central time on March 28, 2013. Response from your physician for any prescriptions requested through FastStart must be received by 11 a.m. Central time on March 26, 2013.

Retail Pharmacy Prescription drugs purchased at a retail pharmacy must be purchased by 11:59 p.m. Central time on March 31, 2013.

IVR and the Internet IVR and Internet refill orders must be completed by 11:59 p.m. Central time on March 31, 2013. You will receive confirmation from CVS Caremark that your IVR and/or Internet refill order is complete.

Telephone Telephone refill orders made through a service associate must be completed by 11 p.m. Central time on March 31, 2013. You will receive confirmation from the service associate that your refill order is complete.

Important: The earliest date that a prescription is **eligible** to be refilled is printed on your mail order label or you can visit CVS Caremark's website at **caremark.com** for your next fill date. Prescription drugs not eligible for refill until April 1, 2013, or later will be processed under the April 1, 2013, copayment and out-of-pocket amounts, regardless of when the refill order is placed.

NEW! *Dental Coverage With the AT&T Dental Plan*

Beginning April 1, your dental program will change to the AT&T Dental Plan with CIGNA, the benefits administrator. Under the PPO option, when you and your eligible dependents receive care from a network provider, your savings will be significantly greater than when you visit a non-network provider.

The AT&T Dental Plan covers services such as routine cleanings, oral exams, fluoride treatments and X-rays as well as many basic and major restorative services. Preventive dental services are covered at 100 percent with no deductible.

Note:

You are not eligible for dental coverage until you reach the first of the month in which you attain six months of net credited service with AT&T. Once you meet this requirement, your coverage will be subsidized, which means that the company will share the cost of your coverage.

PPO Network vs. Non-Network – What it Really Means Although you can visit any licensed dentist or specialist inside or outside of the PPO network, your savings will be significantly greater when you receive care from a provider in the network. PPO Network dentists have agreed to special discounted rates for our employees. Since non-network dentists have not agreed to the discounted rates, they can bill you for the difference between what the plan pays and what they charge for the service rendered. What does that really mean? You could get a filling at a non-network dentist and end up paying over seven times the amount you would have paid if you went to a network provider.

Even if your general dentist is not in the network, you can still save money by using a network provider when referred to a dental specialist (i.e., oral surgeons, endodontists and orthodontists). Dental specialists typically have higher fees associated with each visit, so choosing a network specialist can lower your cost considerably. It's also a good idea to visit the AT&T Benefits Center website, **resources.hewitt.com/att**, to review your dental health plan comparison charts.

A Bigger Dental Network and Bigger Savings

More PPO network providers mean more convenience and more savings for you. In fact, the PPO network has tripled in the past six years. There are now 200,000+ providers available to AT&T employees. Go to **mycigna.com** to check out the list of PPO network providers in your area. You might find additional providers conveniently located near you.

Dental Coverage Overview Effective April 1, 2013 The following is an overview of the benefits under your dental plan:

BENEFIT	NETWORK	NON-NETWORK
Annual Deductible	$25 per individual	$50 per individual
Annual Maximum	$1,750 per individual/yr. (network and non-network combined)	$1,300 per individual/yr. (network and non-network combined)
Orthodontic Lifetime Maximum	$2,000 per individual (network and non-network combined)	$1,400 per individual (network and non-network combined)
Preventive	100% covered; deductible waived	
Basic (Fillings, Extractions)	90% of contracted rate covered after deductible	70% of reasonable and customary rate covered after deductible
Major (Inlays, Crowns, Bridges) and Orthodontia	80% of contracted rate covered after deductible	50% of reasonable and customary rate covered after deductible

NOTE: To review your current dental coverage, visit the AT&T Benefits Center website to review your current dental health plan comparison chart.

Getting Dental Care: PPO Cost-Comparison Examples The following examples compare costs of network and non-network services as well as potential savings. **These examples are for illustrative purposes only** and may not represent actual dentist charges in your area.

PROCEDURE DESCRIPTION	DENTIST CHARGE	R & C RATE[1]	CIGNA CONTRACT RATE	THE PLAN PAYS[2]	YOU PAY[2]
Filling – Basic Service **Network:** Covered 90% **Non-Network:** Covered 70%	$180	$175	$77	**Network:** $69.30	**Network:** $7.70
				Non-Network: $122.50	**Non-Network:** $57.50
Porcelain Crown – Major Service **Network:** Covered 80% **Non-Network:** Covered 50%	$1,230	$1,215	$654	**Network:** $523.20	**Network:** $130.80
				Non-Network: $607.50	**Non-Network:** $622.50
Root Canal (Molar) – Basic Service **Network:** Covered 90% **Non-Network:** Covered 70%	$1,400	$1,397	$785	**Network:** $706.50	**Network:** $78.50
				Non-network: $977.90	**Non-network:** $422.10

[1]Reasonable and customary rate
[2]Assumes deductible satisfied

Monthly Dental Contributions

The following contributions apply to full-time employees with at least six months of net credited service.

2013 DENTAL MONTHLY CONTRIBUTIONS	
Individual	$3
Individual + 1	$9
Family	$16

Dental Health Maintenance Organization

The dental health maintenance organization (DHMO) will still be offered in certain areas. Benefit levels may change for this midyear enrollment, so review the dental health plan comparison charts carefully. You may choose the DHMO option if it is available in your area. To receive DHMO benefits, you must use a DHMO provider.

NEW! Outside-Network-Area Option The majority of participants will have only the network option available to them because network providers are readily available in the areas where they live. A small group of participants live in areas that do not have network providers nearby. This group will be eligible for the outside-network-area (ONA) option. Those enrolled in the PPO option today, who do not live in the PPO service area, will be assigned to the ONA option for annual enrollment. Network or ONA coverage is based on your home ZIP code, and provider network options can change from year to year.

Benefits in the ONA Option are Equal to Network Benefits If you are assigned ONA coverage for April 1, 2013, you can use any dental care provider you wish and receive the same level of benefits (deductible, coinsurance, maximums) as someone with network coverage. However, if you use a network provider, your out-of-pocket expense could be lower because those providers have agreed to special discounted rates for our employees.

NEW! *CIGNA Dental Oral Health Integration Program*

Supporting Your Oral Health Good oral health habits are fundamental, which is why the AT&T Dental Plan covers preventive services such as cleanings and exams at 100 percent with no deductible. Going a step further, clinical research indicates that oral health also may have an impact on overall health. Recognizing this important link, your dental coverage now includes the new Dental Oral Health Integration Program. This new program provides certain procedures and enhanced dental coverage, above what the plan already covers, if you have certain medical conditions.

Reimbursement for Eligible Medical Conditions If you have any of the following medical conditions, you qualify for 100 percent reimbursement of your dental coinsurance for certain related dental procedures (the deductible does not apply):

- Maternity
- Stroke and cardiovascular disease
- Diabetes
- Head and neck cancer radiation
- Organ transplants
- Chronic kidney disease

There's no additional charge for the program.

The Savings Continue When you submit a reimbursement form for a covered procedure, CIGNA will provide up to 50 percent off average retail prices on the following prescription dental products through the CIGNA Home Delivery Pharmacy. These products are specifically made to treat and reduce the risk of gum disease and tooth decay:

- Chlorhexidine prescription anti-bacterial rinses
- Fluoride prescription toothpaste
- Fluoride prescription rinses
- Fluoride prescription gel

Program participants also can request free samples and discounted nonprescription dental products developed for patients with a higher risk for gum disease and cavities. Find out more about the Oral Health Integration Program by visiting **mycigna.com**.

Using the CIGNA Dental Oral Health Integration Program

Step 1: Visit your dentist for the covered service and pay your usual coinsurance amount for that procedure.

Step 2: Complete the reimbursement form and check off any additional information you may want about CIGNA Home Delivery Pharmacy discounts and/or behavioral articles. To obtain a reimbursement form, go to **mycigna.com** or call 888-722-5505.

Step 3: Mail your completed form and required documentation (proof of payment, itemized receipt from dentist, EOB or dentists' completed claim form) to CIGNA at the address listed on the form.

NEW! *Changes to Your Vision Program*

Beginning April 1, your vision program will change from the Cingular Wireless Vision Plan to the AT&T Vision Program. EyeMed Vision Care will continue to be the benefits administrator, so there is no need to change providers.

With an increased emphasis on healthy living and a wealth of information available at the click of a mouse, it's easier than ever to improve your overall health. But often times, one of the most important elements of your health gets overlooked: your vision.

Here are the highlights when you use network providers:

- One free eye exam every 12 months (previously a $15 copay)
- You're eligible for new frames every 12 months (previously every 24 months)
- Increased frame allowance to $130 (previously $120)
- Standard progressive lenses are covered at 100 percent (previously not covered)
- Premium progressive lenses will have a $112 allowance. You will be responsible for anything over the allowance (previously not covered)
- Standard polycarbonate lenses are covered at 100 percent for your entire family (previously a $30 copay for ages 19 and older)
- Second pair benefit, available every 24 months (different copays and allowances apply)

Note: Changes are only applicable if you use network providers, and benefit eligibility is calculated from the date when you last received that service. Review your online enrollment materials on the AT&T Benefits Center website for more information about all of the covered services and your applicable monthly premium. To find a network provider near you, go to **eyemedvisioncare.com**. You must login to access the complete list of EyeMed network providers for AT&T.

Note:

You are not eligible for vision coverage until you reach the first of the month in which you attain six months of net credited service with AT&T. Once you meet this requirement, your coverage will be subsidized, which means that the company will share the cost of your coverage.

NEW! *Health Reimbursement Accounts*

This article does not apply to employees in Puerto Rico.

If you are a current AT&T employee (hired or rehired on or before Dec. 31, 2012), and enroll in the Cingular Wireless Health and Welfare Benefits Plan (National Bargained Benefit Plan)*, you will be enrolled automatically in a health reimbursement account (HRA). No other action is required on your part. If you are enrolled in the National Bargained Benefit Plan on the HRA crediting date (on or about April 1 in 2013 and Jan. 1 in 2014), the company will credit the amount shown in the chart on the following page to your account.

*Employees who are enrolled in Fully-Insured Managed Care options made available by the company – for example, HMSA in Hawaii – are not eligible for an HRA under this provision.

HRAs are a great way to save on health care expenses. You can use the amounts available through your HRA to reimburse yourself for eligible network or non-network medical, dental and vision services and prescription drugs that are not covered by your medical plan.

If you elect to participate in the plan and make your monthly contributions through payroll deduction on an after-tax basis, you can also use your HRA to reimburse yourself for those contributions. During this midyear enrollment, you will have the opportunity to choose either before- or after-tax contributions. You must elect after-tax contributions if you intend to seek reimbursement for your monthly health care contributions.

If you don't make an election, your contributions will default to a before-tax basis. You will not have an opportunity to change that election until the next annual enrollment or until you have a qualified status change that permits you to change your election (for example, adding coverage for a newborn).

If you elect before-tax contributions or are defaulted to before-tax contributions, your monthly health care contributions will be made before federal taxes are calculated and you will not be able to be reimbursed for your monthly contributions.

How an HRA Works In late April, you will receive a welcome letter from ADP, the HRA claims administrator, letting you know that your account has been set up, and that you have amounts (see chart on the following page for amounts) available to reimburse yourself for eligible out-of-pocket expenses. Once you receive your welcome letter, you can call ADP or go online to check your available balance, order claims forms or check the status of a claim. You also may sign up for direct deposit to have claims paid directly to your bank account.

HRA Reimbursement is Easy After you've incurred an eligible expense, you simply fill out a claim form from ADP and mail it in along with proof of the expense. ADP will reimburse you via check or direct deposit (your choice).

HRA AMOUNTS FOR 2013 – 2014		
	In 2013	In 2014
Individual	$500	$500
Family	$500	$500

The full amount credited for the year will be available for reimbursement in late April, for eligible expenses incurred on or after April 1, 2013. Any unused amounts in your account will carry over to the next year while you continue to participate in the HRA program. Also, you are not required to pay taxes on the money you are reimbursed for eligible health care expenses from the HRA.

A summary plan description (SPD) for the AT&T HRA program will be available in the first quarter of 2013. Refer to this SPD for more information on how the HRA works.

MedPlus is Now CarePlus Supplemental Benefit Program

- MedPlus has merged into CarePlus. CarePlus is a supplemental benefit program which provides additional coverage for certain approved procedures and services typically not covered under the medical plan.
- The list of covered procedures and services is the same for CarePlus as it was for MedPlus.

CAREPLUS MONTHLY PREMIUMS		
	Previous Amounts	Beginning April 1
Individual	$4	$1
Family	$6	$2

For More Information on CarePlus For a list of CarePlus covered procedures and services, review the current CarePlus Summary of Material Modifications (SMM) on the AT&T Benefits Center website at **resources.hewitt.com/att**. From the home page, choose "Knowledge Center" and then "Resources and Tools" from the drop down menu. The list is reviewed at least annually. If you have questions, you can call UnitedHealthcare at 877-261-3340. Benefits representatives are available from 7 a.m. to 7 p.m. Central time.

Changes to Life Insurance Coverage Options

Life Insurance and Accidental Death and Dismemberment Coverage Your life insurance options are changing. You now have additional levels or new coverages for life and accidental death and dismemberment (AD&D) insurance for employees, spouses/partners and children.

For more information, visit the AT&T Benefits Center website at **resources.hewitt.com/att** or call 877-722-0020. You also can find insurance coverage estimators and other helpful resources on the MetLife website. Visit **metlife.com** and click on "Calculators and Tools" at the bottom of the page.

Are you a non-smoker? Don't miss this info.

Life Insurance Contribution Rates now Include Smoker/Non-smoker Designation Beginning April 1, employee and spouse/legally recognized partner life insurance contribution rates will default to the "smoker" designation. If you or your covered spouse/legally recognized partner is a non-smoker but you don't choose the correct designation, you will pay higher rates than necessary. If this applies to you, simply choose the "non-smoker" option within your elections for this benefit.