Summary Plan Description

Important Benefits Information

AT&T Mobility Disability Benefits Program

This is an updated summary plan description (SPD) for the AT&T Mobility Disability Benefits Program (formerly named the Cingular Wireless Disability Benefits Plan for Nonbargained Employees, and also known as the EDGE disability plan), a component program under the AT&T Umbrella Benefit Plan No. 1. This SPD replaces your existing SPD dated March 2003 and summaries of material modifications (SMMs) to that SPD.

Please keep this booklet for future reference.

DISTRIBUTION

Distributed to all employees (including LTD recipients) of Cingular Wireless Employee Services, LLC (except Bargained Employees represented by CWA District 6) and CCPR Services, Inc.

NIN 78-13123

IMPORTANT INFORMATION

This SPD is the official document of the AT&T Mobility 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, subject to any applicable collective bargaining obligation. Participation in this Program is neither a contract nor a guarantee of future employment.

Este documento contiene un resumen, en inglés, al AT&T Mobility Disability Benefits Program. Si usted tiene dificultad en entender este documento, entre en contacto por favor con Nationwide Better Health, **866-453-2837** (866-4LEAVES).

HOW DO I USE THIS DOCUMENT?

As you read this Program SPD, pay special attention to the key points at the beginning of most major sections and the 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 Program SPD in its entirety, so that you can understand all of the Program details.

Also, you need to keep your SPDs and SMMs so you can refer to them in the future. They are the primary resource for your questions about the Program.

If you still have questions about the Program after reading the SPD, you can call the Claims Administrator at the phone number listed in the "Contact Information" section beginning on Page 36 of this SPD.

This SPD is provided for your information and review.

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USING THIS SUMMARY PLAN DESCRIPTION

KEY POINT

A. The Program provides Short-Term Disability Benefits, Long-Term Disability Benefits, Supplemental Long-Term Disability Benefits and Vocational Rehabilitation Benefits to Eligible Employees.

This is the current summary plan description (SPD) for the AT&T Mobility Disability Benefits Program as in effect on Jan. 1, 2008. Refer to the prior SPD (and any associated summaries of material modifications to that SPD) for more information regarding claims incurred before Jan. 1, 2008.

The AT&T Mobility Disability Benefits Program is a Program under the AT&T Umbrella Benefit Plan No. 1.

AT&T Inc., as the Plan Sponsor of the Program, intends to continue the Program described within this SPD. However, AT&T reserves the right, at any time and for any reason, to change, modify or terminate any of the terms, conditions or benefits of the Program subject to any obligation under a collective bargaining agreement.

The Program provides four types of benefits: Short-Term Disability Benefits (STD), Long-Term Disability Benefits (LTD), Supplemental Long-Term Disability Benefits (Supplemental LTD) and vocational rehabilitation.

Important changes effective Jan. 1, 2008

Management Employees (including nonexempt, nonbargained Employees who are not covered by a collective bargaining agreement) are ineligible for the Program if the first day that Disability benefits are paid (the first day after the initial Waiting Period) is on or after Jan. 1, 2008. See the definition of Eligible Employee in the Definition section on Page 28 for more information about who is still eligible for the Program.

The paid time off (PTO) supplement provision will be discontinued for new STD claims.

For Bargained Employees whose first day of Disability absence is on or before Dec. 31, 2007, PTO supplement elections will be maintained until you return to work or until available balances are exhausted.

For management Employees (including nonexempt, nonbargained Employees) whose first day of Disability benefits are paid under the Program on or before Dec. 31, 2007, PTO supplement elections will be maintained until you return to work or until available balances are exhausted.

Capitalized terms are defined in the "Definitions" section beginning on Page 28.

ELIGIBILITY FOR THE PROGRAM

KEY POINTS

A. Regular full-time and regular part-time Bargained Employees of participating companies are eligible for the Program.

B. Management Employees (including nonexempt, nonbargained Employees who are not covered by a collective bargaining agreement) are ineligible for the Program if the first day that Disability benefits are paid (the first day after the initial Waiting Period) is on or after Jan. 1, 2008.

C. Management Employees (including nonexempt, nonbargained Employees who are not covered by a collective bargaining agreement) are not eligible for LTD benefits or Supplemental LTD benefits under the Program.

D. Temporary Employees, leased employees, staffing agency employees and independent contractors are not eligible for the Program.

If you are eligible for this Program, you are not eligible for any other disability benefit plan or program sponsored by any other member of the AT&T Group of Companies. The payroll and worker classification records of the Employer shall govern in determining whether an individual is an Eligible Employee.

Bargained Employees

You are eligible for this Program if you are both:

- A regular full-time or regular part-time Employee (classified as regularly scheduled to work 20 or more hours per week as determined by the payroll and worker classification records of the Employer.
- A Bargained Employee who is employed by Cingular Wireless Employee Services, LLC or CCPR Services, Inc. who meets all of the requirements set forth below or otherwise contained in the Program.

    1. You must have completed at least six months of Net Credited Service (See the “When Coverage Becomes Effective” section on Page 16 for more information.)
    2. In order to receive benefits, you must have been Actively-at-Work on the last scheduled work date before your Date of Disability.

If you are a Bargained Employee who is temporarily promoted to a management position (also known as an acting title), you will **not** be eligible for benefits under the Program. Refer to the AT&T Disability Income Program SPD to determine your rights to benefits.

If you are a Bargained Employee who is demoted from a management position with Cingular Wireless Employee Services, LLC or CCPR Services, Inc. or is returning from a temporary promotion, you will be eligible for benefits under the Program if otherwise eligible.

If you are not an Eligible Employee upon the completion of the seven-day Waiting Period, you may be eligible for a leave of absence. If you are on a leave of absence, you shall continue to be eligible for benefits under the Program only if the terms of the leave of absence provide for

continued eligibility for benefits under the Program. Refer to your Employer's leave of absence policy for more information on any leave of absence you may be eligible to receive.

Nonbargained Employees

Effective through Dec. 14, 2005, the employees of AT&T Wireless Services, Inc.; AT&T Wireless Services of Florida, Inc.; McCaw Cellular Communications of Texas, Inc.; AT&T Wireless Services of Hawaii, Inc.; Cellular Services, Inc.; and Claircom Communications Group, Inc. and their subsidiaries and any successor entities were not be eligible for benefits and were excluded from participation in this Program.

All management Employees (including nonexempt, nonbargained Employees who are not covered by a collective bargaining agreement) who are receiving STD benefits under the Program as of Dec. 31, 2007, will continue to be eligible for STD benefits (including paying employee contributions for Supplemental LTD benefits, if applicable) under the Program until you return to work on a regular schedule (not including Partial STD). Upon your return to work, management Employees (including nonexempt, nonbargained Employees who are not covered by a collective bargaining agreement) may be eligible for the AT&T Disability Income Program. Refer to the AT&T Disability Income Program SPD to determine your rights to benefits.

Effective Jan. 1, 2008, management Employees (including nonexempt, nonbargained Employees who are not covered by a collective bargaining agreement) are not eligible for LTD benefits or Supplemental LTD benefits under the Program. Refer to the AT&T Disability Income Program SPD to determine your rights to benefits.

Other Individuals Not Eligible for the Program

The following individuals, as classified by the Employer's payroll and worker classification records, are not eligible for the Program, whether or not they are deemed to be common law employees:

- Temporary Employees
- Leased employees
- Temporary/staffing agency employees
- Persons who provide services to the Employer pursuant to an agreement between the Employer and any other person or organization
- Independent contractors

SHORT-TERM DISABILITY BENEFITS

KEY POINTS

A. *To qualify for STD benefits, an Eligible Employee must be absent from work and be unable to perform the duties of his or her Customary Job due to illness (including pregnancy) or injury for more than seven (7) consecutive calendar days after the approved Date of Disability.*

B. *You will receive 100 percent or 60 percent of STD benefits based on your completed NCS as of your initial Date of Disability.*

C. *Generally, if you are receiving STD benefits under the Program, successive periods of Disability due to injuries received in the same or different accident, or due to the same or different illness, will be considered one period of Disability.*

D. *If you are Disabled and receive 26 weeks of STD benefits under the Program and continue to be Disabled after the expiration of STD benefits, you will be eligible to apply for LTD benefits, and your employment status will be terminated in accordance with an Employer's leave policies, unless you are on an approved Expiration of Disability Benefits leave of absence.*

To qualify for STD benefits, you must be absent from work and be unable to perform the duties of your Customary Job (that is, the work activity that you were hired to regularly perform for the Employer and that serves as your source of income from the Employer) due to illness (including pregnancy) or injury for more than seven (7) consecutive calendar days after the approved Date of Disability. If the seven-day period is interrupted by a return to work, a new seven-day Waiting Period must be completed before Plan benefits commence.

STD benefits are not payable until you are out for seven (7) consecutive calendar days. This period of time is called the Waiting Period. STD benefits and regular pay are not payable under the Program for the Waiting Period. During the Waiting Period, you may use available PTO, vacation and/or illness pay, if applicable. Your supervisor, at your request, will enter these days in the Employer's payroll system.

In order to be approved for STD and in order to remain eligible for continued STD at any time during a Disability, you must be receiving and comply with Appropriate Care and Treatment. Additionally, you must comply with all claim filing requirements, information requests and other requests by the Claims Administrator or Plan Administrator (including, but not limited to, requests to submit to an independent medical examination) in order to be approved for STD or continued STD.

How STD Benefits Are Calculated and Paid

The calculation of the amount of your STD benefits will be based on a daily benefit rate that is determined by dividing your Pay by 364. "Pay" generally means your annual basic wage rate as of the first day that you are scheduled to receive STD benefits. See the Definitions section on Page 28 for a more complete description of Pay. STD benefits are then paid for each day you are Disabled and entitled to benefits, regardless of whether that day would have been a workday, weekend or holiday.

You will receive 100 percent or 60 percent of Pay based on your completed NCS as of your initial Date of Disability in accordance with the schedule below.

Once you have been qualified for STD benefits by the Claims Administrator, STD benefits are payable beginning with the first day after satisfaction of the initial Waiting Period. STD benefits are not payable until the Claims Administrator approves your claim for benefits.

Short-Term Disability Benefits Schedule

Completed NCS at Initial Date of Disability	Weeks at Full Pay (100 Percent of Pay)	Weeks at Partial Pay (60 Percent of Pay)
6 months but less than 2 years	2	24
2 but less than 3 years	4	22
3 but less than 4 years	6	20
4 but less than 5 years	8	18
5 but less than 6 years	10	16
6 but less than 7 years	12	14
7 but less than 8 years	14	12
8 but less than 9 years	16	10
9 but less than 10 years	18	8
10 but less than 11 years	20	6
11 but less than 12 years	22	4
12 but less than 13 years	24	2
13 or more years	26	0

No STD or Partial STD Benefits will be paid if you do not return to work when you are approved under an Employer's Return to Work Policy or Transitional Return to Work Policy, as applicable.

Ordinarily, your STD benefit payments, after approval, will be mailed to you on a weekly basis by the Claims Administrator. However, an Employer may, at its sole discretion, direct that your benefits for continued Disability be paid monthly.

Partial STD Benefits

Partial STD Benefits means the reduced amount of STD benefits you will receive during your transition period back to full productivity work for the Employer, in accordance with the Employer's Return to Work Policy (RTW) or Transitional Return to Work Policy (TRTW).

> **Important**: You are eligible for Partial STD Benefits only following a period of Total Disability.

Eligibility for Partial STD Benefits is based medical documentation from your Physician stating that you are capable of a reduced work schedule. You are required to accept Partial STD Benefits if the reduced work schedule can be accommodated by your Employer.

Your Partial STD Benefits are calculated by reducing your daily STD benefit rate to reflect the number of hours per day that you are able to work, and for which you are compensated, during your transition period. No Partial or Total Disability benefits will be paid if you do not return to work following approval of your transitional return to work by your Physician and the Employer.

The days you are approved for Partial STD Benefits and work a partial work schedule will count as full days against your maximum Disability period.

If you receive both Total and Partial STD Benefits during the same Disability period, the number of weeks you can receive Partial STD benefits at 100 percent or 60 percent of Pay will be reduced by the number of weeks that you receive Total Disability benefits. Under no circumstances can you receive more than the maximum number of weeks of STD benefits when Total and Partial STD periods are combined.

Recurrent Period of STD Disability

STD Disability benefits are payable for each single period of Disability.

If you are receiving STD benefits under the Program, successive periods of Disability due to injuries received in the same or different accident, or due to the same or different illness, will be considered one period of Disability and will be limited to a maximum of 26 weeks unless the periods of Disability are separated by your return to Active Employment for at least 42 consecutive calendar days.

Successive periods of Disability when you have not returned and completed 42 consecutive calendar days of Active Employment will be combined in calculating the number of weeks you receive 100 percent of pay and 60 percent of pay. Under no circumstances can you receive more than the 26 weeks of STD benefits when any previous and current STD Disability periods are combined.

Employment After Receiving STD Benefits

If you are Disabled and receive 26 weeks of STD benefits under the Program and continue to be Disabled after the expiration of STD benefits (and therefore you are unable to return to work), you will then be eligible to apply for LTD benefits. Additionally, your employment status will be terminated in accordance with an Employer’s leave policies, unless you are on an approved Expiration of Disability Benefits leave of absence.

If you qualify for LTD benefits and later recover from the Disability, you may reapply for employment with the Employer, but there is no guarantee of re-employment. This includes any individual with a current workers’ compensation claim.

If you are able to return to work after a period of receiving STD benefits, you will be subject to all applicable Employer policies, including the Fitness for Duty Policy. In addition, if you fail to return to work within three days following the end of your STD period, you may be subject to termination.

LONG-TERM DISABILITY (LTD) AND SUPPLEMENTAL LONG-TERM DISABILITY (SUPPLEMENTAL LTD) BENEFITS

KEY POINTS

A. The Program provides LTD and optional Supplemental LTD benefits for disabilities after the exhaustion of the full 26-week STD period.

B. Generally, as long as you continue to meet the definition of Disability, LTD and Supplemental LTD benefits may be available until you reach age 65.

C. Your benefits from Employer-paid LTD and Employee-paid Supplemental LTD are payable at 50 percent of Pay and 20 percent of Pay (if enrolled in Supplemental LTD), respectively.

D. If you have a mental health claim under the LTD benefit, the maximum lifetime benefit period is 24 months.

The Program provides LTD and optional Supplemental LTD benefits for Disabilities that continue beyond the exhaustion of Short-Term Disability benefits (i.e., after the exhaustion of the full 26-week STD period). You are considered Disabled for purposes of LTD and Supplemental LTD if:

- During the first twenty-four (24) months after your exhaustion of STD Benefits, you are continuously unable to perform your Customary Job.
- After the initial twenty-four (24) months, both of these must happen:
  - You are continuously prevented by your Disability from engaging in any employment for which you are qualified or may reasonably become qualified based on education, training, or experience.
  - Your Disability is caused by something other than a mental health claim (this does not apply to mental health claims with organic causes where the cause is determined by the Claims Administrator in its sole discretion).

As long as you continue to meet the definition of Disability, LTD and Supplemental LTD benefits may be available until you reach age 65. The period for which benefits are available will be determined by your age on your initial Date of Disability. See the Duration of LTD and Supplemental LTD Benefits section on Page 13 for more information on when LTD and Supplemental LTD benefits end.

In order to be approved for LTD and Supplemental LTD and in order to remain eligible for continued LTD and Supplemental LTD at any time during a Disability, you must be receiving and comply with Appropriate Care and Treatment. Additionally, you must comply with all claim filing requirements, information requests and other requests by the Claims Administrator or Plan Administrator in order to be approved for LTD and Supplemental LTD or continued LTD and Supplemental LTD.

Note: Your benefits from LTD and Supplemental LTD are reduced by benefit payments from other sources. See the Qualification for LTD and Supplemental LTD Benefits section on Page 12 for more information on the reductions.

Benefit Amount

Your LTD Benefit is 50 percent of Pay. See the Definitions section on Page 28 for a more complete description of Pay. If you have purchased Supplemental LTD coverage, you will receive an additional 20 percent of Pay.

The calculation of the amount of your LTD and Supplemental LTD benefits will be based on a daily benefit rate that is determined by dividing your Pay by 364. LTD and Supplemental LTD benefits are paid for each day you are Disabled and entitled to benefits, regardless of whether that day would have been a workday, weekend or holiday. If your first or last month of LTD or Supplemental LTD benefits is a partial month, the amount of your benefits for that month will be prorated to reflect the partial month.

Qualification for LTD and Supplemental LTD Benefits

Benefits under the LTD and Supplemental LTD provisions of the Program do not depend upon your receiving approval for Social Security disability benefits. However, regardless of the length of your Disability, in order to qualify for benefits under the LTD and Supplemental LTD provisions of the Program, you must apply for Social Security disability benefits. The Claims Administrator may assist you in filing for Social Security disability income.

> **Important**: Social Security uses a different definition of "disability" than the Program. There may be circumstances where you may be considered "disabled" by Social Security but not by the Program.

In addition, you must apply for any other income benefits for which you qualify (for example, workers' compensation benefits); otherwise, the Program can assume that you are eligible and receiving such benefits. Thus, an estimate of other income benefits will be made from your LTD and Supplemental LTD benefits even if you haven't applied for the other benefits. See the "Effect of Other Income on Program Benefits" section on Page 17 for more information on these other benefits. If you fail to communicate the status of your other income benefits, your benefits under the LTD and Supplemental LTD provisions of the Program will cease or will be adjusted by the estimated amount of other income.

You (or someone acting on your behalf) must provide proof that you have done all of the following:

- You and any of your dependents have applied for all other income benefits that you are, or may be, eligible to receive relative to your Disability and have made a timely appeal of any denial through the highest administrative level.
- You have furnished proof needed to obtain other income benefits.
- You have not waived any other income benefits without the Claims Administrator's written consent.
- You have sent copies of the documents to the Claims Administrator showing the effective dates and the amounts of other income benefits.

If you do not furnish proof of your application or your receipt of other income benefits, the Claims Administrator reserves the right to cease payments or adjust benefits by the estimated amount of such other income benefits.

Duration of LTD and Supplemental LTD Benefits

If you qualify for LTD or Supplemental LTD benefits, benefits will be payable on the last day of each month during the continuance of the approved Disability or Total Disability and will cease on the earliest of the following:

- The date of your death.
- The date you no longer meet the definition of Disability or Total Disability as determined by the Claims Administrator.
- The date your approved Disability or Total Disability ends due to your recovery or the date of your failure to comply with the Plan's eligibility, administrative, claims processing or proof of Disability requirements.
- The end of the month in which you turn age 65 if you became Disabled before age 60.
- If you become Disabled after age 60, the maximum benefit duration is five years from the date of your initial Disability, including the STD benefit period.
- If you have a mental health claim under the LTD benefit, the maximum lifetime benefit period is 24 months. If you are hospitalized at the end of the 24-month period, disability benefits will continue only until the hospital confinement ends. This provision does not apply to mental health disabilities with organic causes (where the cause is determined by the Claims Administrator in its sole discretion). Such disabilities will continue as long as you meet the Program's requirements.

VOCATIONAL REHABILITATION

KEY POINT

A. Vocational rehabilitation benefits train you for new employment if you become Disabled.

After a period of any Disability, it may be difficult to return immediately to full-time work even though you are substantially recovered.

The Program includes an incentive feature that allows you to attempt rehabilitation and not jeopardize Total Disability status.

> **Important:** Participation in an Approved Rehabilitation Program and/or Approved Post-Rehabilitation Program is determined at the discretion of the Claims Administrator. If the Claims Administrator determines that you are eligible to participate in one of these programs, participation is voluntary.

Both programs enable you to phase in your return to full-time employment in a manner that supports your health and financial needs. The maximum time period that you may participate in these programs is 24 months, as determined by the Claims Administrator.

The intent of an Approved Rehabilitation Program is to help you develop the skills that will facilitate your return to your Customary Job or another reasonable occupation other than your Customary Job on a full-time basis. While you are engaged in an Approved Rehabilitation

Program, only 50 percent of your earnings from that program will be used to offset your Disability benefits.

Your rehabilitation program will cease to be an Approved Rehabilitation Program on the earliest of these occurrences:

- The date you are able to perform the duties of your Customary Job or another occupation other than your Customary Job for which you are reasonably qualified.
- The date you begin an Approved Post-Rehabilitation Program.
- The date the Claims Administrator withdraws, in writing, its approval of the program.
- You have received 24 months of Vocational Rehabilitation Benefits.

When the Claims Administrator determines that your continued work in an Approved Rehabilitation Program will not result in your physical ability to work at your Customary Job or another reasonable occupation other than your Customary Job on a full-time basis, you may work in an Approved Post-Rehabilitation Program.

While you are engaged in an Approved Post-Rehabilitation Program, on either a full-time or part-time basis, your Disability benefit will be reduced by 60 percent of the earnings from the Approved Post-Rehabilitation Program.

Your post-rehabilitation program will cease to be an Approved Post-Rehabilitation Program on the earliest of these occurrences:

- The date you are able to perform the duties of your Customary Job or another occupation other than your Customary Job for which you are reasonably qualified.
- The date you begin an Approved Rehabilitation Program.
- The date the Claims Administrator withdraws, in writing, its approval of the program.

All rehabilitative employment must be approved in advance by the Claims Administrator and your Physician.

Under no circumstances will the combination of your Disability benefits and income from an Approved Rehabilitation Program exceed your regular monthly earnings, based on your pay in effect at the time of your Disability. If so, a higher percentage of an Approved Rehabilitation Program income will be used to reduce your Disability benefit so that your total earnings do not exceed 100 percent of your pay before Disability.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

KEY POINTS

A. Generally, you are automatically enrolled in STD and LTD benefits under the Plan after you have six months of service.

B. You must enroll for Supplemental LTD benefits.

C. Your STD and LTD coverage will be effective on the first day after you complete six months of service (as described below).

D. If you enroll for Supplemental LTD during your initial enrollment period, coverage will be effective on the same day as your STD and LTD coverage (subject to exceptions described below).

E. If you do not enroll for Supplemental LTD during your initial enrollment period, you will be required to provide evidence of good health and coverage will be effective on the first day of the month after your coverage is approved by the Claims Administrator (subject to exceptions described below).

Initial Enrollment and Effective Date for STD, LTD and Supplemental LTD

There is nothing you need to do to enroll in the STD or LTD benefits. You are automatically enrolled in the benefits under the Plan once you have six months of service. See the "When Your Coverage Becomes Effective" section on Page 16 for more information.

Although enrollment in STD and LTD is automatic, you must enroll in the Supplemental LTD benefits in order to participate. If you do not complete the enrollment within 31 days of your initial enrollment period you will need to provide evidence of insurability rules, which require evidence of good health. You may not enroll in the Supplemental LTD benefits if you are Disabled or receiving benefits under the Program at the time.

Under the Supplemental LTD benefits, you may elect to purchase an additional 20 percent Disability benefit. Combined with the basic LTD benefit, your total benefits payable are equal to 70 percent of Pay.

Once you enroll in Supplemental LTD benefits, you do not have to re-enroll in the Supplemental LTD benefits during later annual enrollment periods. Once enrolled, your prior year's election will continue into the next calendar year(s), or until you provide notification to the Supplemental LTD Enrollment Vendor that you no longer wish to participate in Supplemental LTD benefits. See the *Supplemental LTD Benefits Enrollment Vendor* table on Page 37 for more information on how to contact the Enrollment Vendor.

Late Enrollment for Supplemental LTD

If you do not enroll during your initial enrollment period, you may enroll at a later time. However, certain restrictions apply:

- If you drop coverage and then re-enroll, you will need to provide satisfactory evidence of good health.
- If you do not enroll when you are initially eligible, you are considered a "late enrollee" and will need to provide satisfactory evidence of good health.
- If you are receiving STD or LTD benefits, you will not be allowed to enroll in the Supplemental LTD benefit until you are again Actively-at-Work. You will need to provide satisfactory evidence of good health, however.
- You may not enroll in Supplemental LTD while you are on a leave of absence. You may enroll once you are again Actively-at-Work. You will need to provide satisfactory evidence of good health, however.

- If evidence of good health is required, your Supplemental LTD coverage will be effective the first day of the month following your approval by the Claims Administrator, provided that you are Actively-at-Work on that date.
- You may not enroll in Supplemental LTD if you are Disabled or receiving benefits under the Program at the time.

The Claims Administrator, in its sole discretion, decides if the evidence of good health is satisfactory. If you need to provide evidence of good health, you should contact the Claims Administrator for further information.

When Your Coverage Becomes Effective

Short-Term Disability

Your STD coverage will be effective on the first day after you complete six months of Net Credited Service. If you are not Actively-at-Work on that day, coverage will be effective on the first day you are Actively-at-Work at your Customary Job without restrictions. Benefits are not payable, however, for any Disability that begins before completion of six months of service. Your coverage remains in effect as long as you are an Eligible Employee.

Long-Term Disability

Your LTD coverage will be effective on the first day after you complete six months of Net Credited Service. If you are not Actively-at-Work on your first day of eligibility, coverage will be effective on the first day you are Actively-at-Work at your Customary Job without restrictions. Benefits are not payable, however, for any Disability that begins before completion of six months of service. Your coverage remains in effect as long as you are an Eligible Employee.

Supplemental Long-Term Disability

If you enroll in Supplemental LTD coverage and meet all other requirements to receive Supplemental LTD coverage, your Supplemental LTD coverage will be effective on the first day after you complete six months of Net Credited Service. The Enrollment Vendor will notify you of your initial enrollment period approximately thirty (30) days before you complete six months of service. If you purchase Supplemental LTD coverage during your initial enrollment period and if you are Actively-at-Work without restrictions on the coverage effective date, your Supplemental LTD coverage will be effective the same date as your STD and LTD coverage. If you are not Actively-at-Work on your first day of eligibility, coverage will be effective on the first day you are Actively-at-Work at your Customary Job without restrictions. Benefits are not payable, however, for any Disability that begins before completion of six months of service. If evidence of good health is required, your Supplemental LTD coverage will be effective the first day of the month following your approval by the Claims Administrator, provided that you are Actively-at-Work on that date. See the “Late Enrollment for Supplemental LTD” section on Page 15 for more information about submitting an evidence of good health. Your coverage remains in effect as long as you are an Eligible Employee and continue to make the required contribution for the cost of coverage.

You will be considered to have satisfied the requirement for six months of service when you are credited with at least six months of Net Credited Service. Your service while on an approved unpaid or paid leave of absence in accordance with your Employer’s leave policies will qualify as service for this purpose. In addition, if you are on an approved unpaid or paid leave of absence in accordance with your Employer’s leave policies on the date that you would have completed six months of service, you will be deemed to have met this requirement.

COST OF COVERAGE

The Employer pays the full cost of the STD and LTD coverage. The cost for Supplemental LTD is paid by you through after-tax payroll deductions.

Supplemental LTD rates for each Plan Year will be determined annually using a formula based on prior Supplemental LTD claims experience. You will be notified of any changes in the Supplemental LTD contribution amounts before the effective date of the change.

The rates for Supplemental LTD will be determined using the following calculation method:

- Your Monthly Covered Compensation is divided by $100 for each increment of coverage.
- The result is multiplied by the rate in effect during annual enrollment.
- This cost is your monthly required contribution for Supplemental LTD coverage.

> **Example**: If you are a Bargained Employee, with a Monthly Covered Compensation of $4,000 and the coverage rate for you is $0.543 per $100, your monthly required contribution during 2008 will be:
>
> ($4,000 / $100) x $0.543 = $21.72

> **Important:** If you become Disabled, you will be required to continue your contributions for Supplemental LTD while on STD. Once you begin receiving LTD benefits under the Program, your required Supplemental LTD contributions will be waived and your Supplemental LTD coverage under the Program will remain in effect at no cost to you. This waiver of Supplemental LTD contributions will continue for as long as you qualify for LTD benefits under the Program.

Under current federal income tax law, STD and basic LTD benefits that you receive under the Plan are considered taxable income during the year paid. However, Supplemental LTD benefits are not included in taxable income. Check with your tax adviser to determine if benefits are subject to state income tax.

EFFECT OF OTHER INCOME ON PROGRAM BENEFITS

KEY POINT

A. Benefits under the Program will be reduced by (1) benefits provided or required by federal, state or local government; (2) workers' compensation; (3) Social Security disability benefits and any amount received from a third party related to your Disability.

The STD, LTD and Supplemental LTD benefits you receive under the Program will be reduced to the extent that you qualify for benefit payments from any of the following:

- Disability benefits required or provided under any law of a federal, state or local government. (See the "State Disability Benefits" section on Page 18 for more information on

the state disability benefits if you live in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island.)

- Workers' compensation or similar disability benefits resulting from the same disabling condition.
- Primary and family Social Security disability insurance benefits or old-age Social Security benefits when they first become payable.
- Any amount received from any third party relating to your Disability (without regard to the applicability of any "make-whole" doctrine).

In the event you receive a lump sum award of any of the above types of benefits, your benefits will still be reduced by the full amount of the lump sum, as determined by the Claims Administrator, with no adjustment to the award for attorney's fees. Even if you do not apply for any of the benefits for which you qualify, the Program will reduce your LTD and Supplemental LTD benefits by an estimated amount of the other income benefits for which you would qualify. See the "Qualification for LTD and Supplemental LTD" section on Page 12 for more information on the reductions.

Once your Social Security benefits are determined, it remains the same for LTD and Supplemental LTD benefit offset purposes. That is, any later cost-of-living increases in your Social Security benefits will not decrease your LTD or Supplemental LTD benefit payments.

State Disability Benefits

If your work location is in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, you may be eligible to receive benefits under that state's statutory benefit program in addition to this Program.

The benefits you are eligible to receive under a state or federal statutory benefit program will reduce the STD and LTD benefits you receive under the Program. In addition to the Puerto Rico statutory disability benefits, this Program will also coordinate Program benefits with the benefits payable under the Puerto Rico Working Mothers' Maternity Act.

If you live in one of the above-named states, it is important that you promptly apply for the state's statutory disability benefits *in addition* to the benefits available in this Program because any benefit payment you are eligible to receive under this Program will be reduced by the maximum amount provided by the state's statutory benefit program *until* you provide the proof of the statutory payment to the Claims Administrator.

See the Contact Information section on Page 36 for more information on how to contact the appropriate state agency.

In the event you receive a monthly statutory benefit that is greater than the amount of your STD, LTD or Supplemental LTD benefit, no STD, LTD or Supplemental LTD payment will be made under the Program.

If your work is located in a state other than one of those listed above, and the state where your work is located adopts a disability program, you will be required to apply for benefits, if applicable, and your STD, LTD, and Supplemental LTD benefits will be reduced as described above.

WHEN BENEFITS ARE NOT PAYABLE

The Program's benefits (STD, LTD and Supplemental LTD) are not payable for:

- A Disability that began before your coverage became effective.
- A Disability that commences while you are not Actively-at-Work.
- A Disability or a request for a Disability extension that was filed while you are not Actively-at-Work.
- A Disability that began after your eligibility for coverage ended.
- A Disability that began after you terminated employment or retired, or any period of Disability that continues after you voluntarily submitted your resignation.
- A Disability resulting from illness or injury while engaged in any other occupation(s) for wage or profit or self-employment.
- A Disability caused by an assault, battery or felony attempted or committed by you.
- A Disability caused by insurrection, rebellion or your participation in a riot or civil disturbance.
- A Disability caused by war or any act of war, declared or undeclared, unless you are on Employer business, including travel, assignment and relocation outside the United States.
- Your Disability is caused by your service in the military (a Disability occurring during military leave that is unrelated to your military service is not excluded, however).
- A Disability resulting from a non-medically recognized condition or procedure.
- A Disability for cosmetic surgery, except:
  - Surgery made necessary by accidental injury or illness (including breast reconstruction following a mastectomy).
  - A Disability that is caused by complications from cosmetic surgery may be covered, however, benefits for complications of cosmetic surgery will not begin earlier than the time at which you could have returned from a cosmetic surgery that had no complications.
- Any period of Disability if you are terminated from the Employer for gross misconduct.
- A Disability resulting from intentionally self-inflicted injury or illness or attempted suicide.
- Failure to reimburse a retroactive award from another income source.
- A Disability resulting from illegal drug use.
- A Disability that is not approved by the Claims Administrator.

Exclusions

Regardless of any other provisions of the Program, your STD, LTD or Supplemental LTD benefits shall be denied or cease if:

- Your claim is not filed while you are an Eligible Employee.
- You do not submit to an independent medical examination, functional capacity examination or any other examination determined by the Claims Administrator to be necessary or appropriate for evaluating your claim.
- You do not provide proper medical information about your condition on a timely basis as requested.
- You are not under the Appropriate Care and Treatment of a Physician or are noncompliant with the recommended course of treatment for your condition.
- You fail to cooperate with the requests of the Claims Administrator or Plan Administrator.
- You decline to return to your own job, or another available job assigned by the Employer, when medically able as determined by the Claims Administrator.
- You are currently employed or take full-time or part-time employment with another employer, or work for a self-owned or family-owned business while receiving Disability benefits. You are required to confirm secondary employment before the approval of Disability benefits. Your Disability benefits will cease immediately if it is determined that you are engaged in other employment, unless the other employment was approved in writing by the Claims Administrator in connection with your LTD benefit.
- You leave home to travel out of town for any reason (other than the normal activities required for commuting in your area) without the prior consent of the Claims Administrator.
- A claim is not filed within 60 days from your first day of eligibility for benefits.
- A claim for LTD or Supplemental LTD benefits was not preceded by a STD claim period of twenty-six (26) weeks approved by the Claims Administrator.
- You are entitled to receive any wages paid by the Employer (except if you are receiving wages in connection with an Approved Rehabilitation Program or an Approved Post-Rehabilitation Program).
- A suit for damages or other legal action is brought by you against the Employer because of your injury, except for an action to enforce ERISA rights.
- You have not established your Disability based on credible objective medical evidence, as determined by the Claims Administrator.

If any present or future law provides for payment of Disability benefits, this Program will reduce its payment by any benefits provided by law. However, payments from this Plan will not be reduced because of any benefits paid due to a military service disability that is unrelated to the Disability for which you receive benefits under the Program.

TERMINATION OF COVERAGE

When Coverage Ends

Short-Term Disability

Your STD coverage ends on the earliest of the following:

- The date you cease to be employed with the Employer for any reason

- The date you no longer qualify for coverage as an Eligible Employee
- The date the Program is terminated by the Company for your employment classification
- The date the Company elects to discontinue the coverage

> **Important**: Should your position be designated for surplus while you are out on Disability, your benefits will continue for the duration of your Disability period as long as you continue to meet the Program's definition of Disability. Your termination will be effective when you are released to return to Active Employment.

Long-Term Disability and Supplemental Long-Term Disability

Your LTD and Supplemental LTD coverage ends on the earliest of the following:

- The date you cease to be employed with the Employer for any reason except an approved LTD.
- The date you no longer qualify for coverage as an Eligible Employee.
- The date you cancel Supplemental LTD coverage by giving notice to the Enrollment Vendor. See the *Supplemental LTD Benefits Enrollment Vendor* table on Page 37 for more information on how to contact the Enrollment Vendor.
- The date the Program is terminated by the Company for your employment classification.
- The date the Company elects to discontinue the coverage.
- The date you fail to make any required Supplemental LTD premium contribution.

Conversion

When your STD, LTD or Supplemental LTD coverage ends under the Program, you cannot convert it to an individual policy.

CONTINUATION OF COVERAGE DURING AN APPROVED LEAVE OF ABSENCE OR A FAMILY AND MEDICAL LEAVE

If you are granted an approved leave in accordance with the Family and Medical Leave Act of 1993 (FMLA) or another leave provided under the Employer's leave of absence policy, the Employer will continue your STD and LTD coverage under the Program. You may elect to continue your Supplemental LTD coverage under the Program.

Supplemental LTD coverage will not be continued beyond the first of these occurrences:

- You are required to make any contribution and your payment is more than 30 days late.
- The Employer determines your approved leave of absence or FMLA leave is terminated and you do not return to your Customary Job.
- Coverage is discontinued as to your eligible class.
- The Employer elects to discontinue the STD, LTD or Supplemental LTD coverage under the Program.

If you take an approved leave of absence and return in the same calendar year, your coverage will continue while you are on the leave of absence as long as you make the required contributions for the Supplemental LTD coverage.

If you take an approved leave of absence and do not return until the next calendar year, the coverage you have at the time of your leave of absence will continue while you are on the leave of absence as long as you make timely payments for the coverage. You may elect to make any applicable changes in coverage once you return to your Customary Job.

CLAIMING YOUR BENEFITS

KEY POINTS

A. *You must file Disability claims with the Claims Administrator.*

B. *It is your responsibility to provide credible, objective medical evidence to the Claims Administrator whenever requested.*

C. *The Claims Administrator will determine if you are eligible for benefits under the Program.*

D. *You should file a claim as soon as you know you may be Disabled more than seven (7) consecutive calendar days.*

E. *No Disability claim will be considered for coverage unless it is filed within 60 days of your eligibility for benefits.*

Reporting Your Claims: Claim Approval Process

You must file Disability claims with the Claims Administrator on forms, or as prescribed by the Claims Administrator. All claims should contain all information requested on the forms and any additional information requested by the Claims Administrator. A claim will not be considered to be submitted to the Program until all required and requested information is provided. All information should be provided as soon as practicable. All Disability benefits under the Program may be delayed until all information has been provided.

The Claims Administrator will determine whether you are Disabled under the terms of the Program for STD, LTD or Supplemental LTD benefits. In order to establish your Disability you must present credible, objective medical evidence. The Claims Administrator also may appoint an independent Physician to examine you in order to verify your Disability.

While you are receiving STD, LTD or Supplemental LTD benefits under the Program, you are required periodically to provide the Claims Administrator with supplemental medical information from your Physician documenting your continued Disability. You may also be required to submit to an independent medical examination(s) or a functional capacity examination.

It is your responsibility to provide the documentation supporting your claim on a timely basis. If you fail to submit the documentation requested by the Claims Administrator, or if you refuse to be examined by a Physician appointed by the Claims Administrator in order to verify your Disability or continued Disability, your claim will be denied and your STD, LTD and Supplemental LTD benefits will stop.

See the Contact Information section on Page 36 for more information on how to contact the Claims Administrator.

> **Important**: As soon as you know you may be Disabled more than seven (7) consecutive calendar days, call your supervisor and the Claims Administrator to request certification for benefits under the Program. However, do not call the Claims Administrator for certification earlier than 30 calendar days before your Disability date.

It is your responsibility to provide the necessary information to the Claims Administrator. If you are not able to make the call, the call may be made by:

- Your Physician.
- Your supervisor (upon your request or that of a family member).
- Any designated spokesperson or member of your family.

When the Claims Administrator's certification of a period of Disability ends, you may request that the Claims Administrator certify an extension of the certified period of Disability. If the Claims Administrator does not contact you about recertification, but you and your Physician believe you are still not able to work due to the Disability, you should contact the Claims Administrator. In your best interest, this should be done no later than the last day for which your Disability is presently certified. If this is done by then, you will know on a timely basis if the period of Disability will be recertified. The call should be made even if the reason you are asking for recertification is due to a different disease or injury that has occurred during the certified period of Disability. Written notice of any recertification decision will be sent promptly to you and your Employer.

The Company reserves the right to change the Claims Administrator at any time for any reason.

Claim Filing Limitation

To receive Disability benefits, you should file a claim as soon as you know you may be Disabled more than seven (7) consecutive calendar days. When you file for STD benefits, there is a period of time that it will take you and your Physician to get your paperwork to the Claims Administrator and for the Claims Administrator to approve your Disability claim. Therefore, make sure that you file your claim information as soon as possible.

If your claim is not reported to the Claims Administrator within the first seven (7) calendar days of your absence, your supervisor may contact the Claims Administrator on your behalf to initiate the claim for you. Only minimal information will be required for input by your supervisor. Your supervisor will not require any medical information from you to file your claim for you. The Claims Administrator will then contact you to complete the claim.

If you exhaust your STD benefits and you transition to LTD, the Claims Administrator will work with you before the transition to notify you that it is time for you to file for LTD benefits.

No Disability claim will be considered for coverage unless it is filed within 60 days of your eligibility for STD, LTD and Supplemental LTD benefits, respectively.

In addition, all claims must be filed while you are Actively-at-Work.

FINAL UNPAID BENEFITS UNDER THE PROGRAM

If you die while receiving benefits under the Program, your final payment will be made to your surviving spouse or to your estate if you do not have a surviving spouse.

CLAIMS AND APPEAL PROCESS UNDER THE PROGRAM

KEY POINTS

A. If you think you are entitled to a benefit under the Program, you may file a claim for benefits in writing.

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

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

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

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

The Plan Administrator, the Claims Administrator and each person to whom review authority has been delegated shall have full and exclusive authority and discretion to grant and deny claims and appeals under the Program. The decision of the Plan Administrator, Claims Administrator or any delegate, as applicable, on any claim or appeal, in accordance with the claim and appeal procedures, shall be final and not subject to further review.

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 made. 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 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 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 on which the denial is based, where applicable.
- If applicable, a statement that an internal rule, guideline or 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.

- 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 named Fiduciary.
- A statement concerning your right to file a civil action under ERISA after the required review has been completed.

If your claim is denied in whole or in part 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.

If you or your authorized representative send 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.
- Reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.
- 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.

A qualified individual who was not involved in the decision to deny your initial claim will be appointed to decide the appeal. This individual will decide the claim 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 appeal is related to clinical matters, the review will be done in consultation with a Physician 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 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 will be decided entirely on the basis of evidence submitted in writing, and you are not entitled to a hearing, the right to present oral testimony or cross-examine authors of written evidence submitted.

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 named Fiduciary may take an additional 45 days to reach a decision, but you must be notified in writing that there will be a delay.

If your appeal is denied, 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.
- A statement concerning your right to file a civil action under ERISA.

If your appeal is denied, it is final and not subject to further review by the named Fiduciary unless a court of competent jurisdiction shall determine that the Claims Administrator has abused its discretion in deciding to deny the claim. However, you may have further rights under ERISA, as provided in the following section. 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 claims and appeal process described in this section. A legal action may not be filed until you have completed the claim and appeal process. Legal action involving the Program should be filed directly against the AT&T Mobility Disability Benefits Program. See the *Plan Information* table beginning on Page 33 to determine the Agent for Service of Legal Process for the Program.

Any legal action based on a denial of eligibility and/or for benefits under the Program must be filed no later than five years after the date of the denial by the Claims Administrator to whom the claim authority has been assigned.

As a requirement for receiving benefits from the Program, each Eligible Employee shall 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 his claim. Such authorization shall be treated as a waiver of all provisions of law forbidding such disclosure.

ERISA RIGHTS OF PARTICIPANTS AND BENEFICIARIES

KEY POINTS

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

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

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

As a participant in the AT&T Umbrella Benefit Plan No. 1 (the Plan), which includes the AT&T Mobility Disability Benefits Program, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Receive information about your Plan and the benefits offered under the Program.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports (Form 5500), which

also are available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents are usually available for review during normal working hours at the Plan Administrator's office. If participants or Beneficiaries of deceased participants are unable to examine these documents there, they should write to the Plan Administrator and specify the documents to be examined and at which Participating Company work location they wish to examine them. Copies of the documents will be made available for examination at that work location within 10 days of the date the request was submitted.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated SPD and benefit summaries. The Plan Administrator may make a reasonable charge for the copies. Employees or Beneficiaries should write to the Plan Administrator.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and Beneficiaries. No one, including your Participating Company, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining any Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for any Plan 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 the Plan or Program documents, including the benefit summaries or the latest annual report from the Plan, 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 material, unless the materials were not sent because of reasons beyond the control of the Plan 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If that Plan Fiduciary should misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in 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 that your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, 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 Benefit Security Administration (formally known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or at:

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

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

DEFINITIONS

Active Employment or Actively-at-Work means all of the following:

- You are either on approved leave or you are classified by the Employer as actively working for the Employer, performing the material duties of your Customary Job without limitations or restrictions at (i) your usual place of business or (ii) some other location that the Employer's business requires you to be.
- You have not been suspended or terminated by the Employer.
- You are not incarcerated.
- You are a citizen or legal resident of the United States.
- You are not a temporary or seasonal Employee.
- You are not receiving Partial STD Benefits.

Appropriate Care and Treatment means medical care and treatment during a period of Disability that meets all of the following:

- You must be currently under continuous care and treatment from a Physician or licensed mental health care provider whose medical training and clinical experience are appropriate for treating your Disability.
- You must follow and be compliant with the recommended course of treatment.
- It is necessary to meet your basic health needs and is of demonstrable medical value.
- It is consistent in type, frequency and duration of treatment with relevant guidelines of national medical research and health care coverage organizations and governmental agencies.
- It is consistent with the diagnosis of your condition.
- Its purpose is to maximize your medical improvement.

> **For Example**: If you have a Disability claim for a mental health condition (i.e., anxiety, depression, etc.), you must be under the care of a duly licensed mental health professional in order for your claim to be approved. Any duly licensed mental health care professional will be deemed to be a Physician under the terms and conditions of this Program.

Approved Rehabilitation Program means a formal physical, mental or vocational rehabilitation program, approved by the Claims Administrator, which is expected to result in your return to full productivity at your Customary Job or a reasonable occupation on a full-time basis.

Approved Post-Rehabilitation Program means a period of part-time work at your Customary Job or at another reasonable occupation, approved by the Claims Administrator, which is not expected to result in your return to full productivity at your Customary Job.

AT&T or **Company** means AT&T Inc., formerly known as SBC Communications 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 means any Employee whose job title and classification are included in a collective bargaining agreement between an Employer and a union that has agreed to the benefits provided under the Program.

Claims Administrator means the third-party vendor that the Company has contracted with to administer the Plan. The Company has delegated fiduciary responsibilities, as defined by the Employee Retirement Income Security Act of 1974, for claims administration to the Claims Administrator. See the Contact Information section on Page 36 for more information on how to contact the Claims Administrator.

Coverage Effective Date means the date when you first meet all of the requirements that qualify you as an Eligible Employee under the Program.

Customary Job means the work activity that you were hired to regularly perform for the Employer and that serves as your source of income from the Employer.

Date of Disability means the date that the Claims Administrator, following its review of the supporting medical documentation provided by your treating Physician(s), deems you were first Disabled under the terms and conditions of this Program.

Disabled or Disability generally means a period during which an Eligible Employee has been approved for STD, LTD or Supplemental LTD by the Claims Administrator.

Disability or Disabled,
For STD purposes, means that due to illness (including pregnancy) or injury, you are absent from work and unable to perform the duties of your Customary Job, and you meet the other requirements contained in the Plan and this Program.

For LTD and Supplemental LTD purposes, means that following the exhaustion of STD benefits under the Program (i.e., the full 26-week period of STD) and due to an illness or injury, you are continuously unable to perform your Customary Job for the first twenty-four (24) months after your exhaustion of STD benefits under the Program. After twenty-four (24) months following your exhaustion of STD benefits under the Plan, you must meet the definition of Total Disability to continue to receive Disability benefits under the Program.

Eligible Employee means an individual who satisfies the requirements as described in the "Eligibility for the Program" section beginning on page 6.

Employee means an individual who is classified as an employee in the payroll and worker classification records of Cingular Wireless Employee Services, LLC, or CCPR Services, Inc.

Employer means Cingular Wireless Employee Services, LLC, or CCPR Services, Inc.

ERISA. ERISA refers to the Employee Retirement Income Security Act of 1974, as it may be amended from time to time, and the final regulations issued thereunder by the U.S. Secretaries of Labor and the treasury.

Long-Term Disability and Supplemental Long-Term Disability mean the period, immediately following a period of 26 weeks for which STD benefits have been paid, for which LTD benefits are payable under the Plan for a Disability or Total Disability, when applicable. If you are on Expiration of Benefits leave, in accordance with the Employer's leave policies, following the expiration of your STD benefits, Long-Term Disability and Supplemental Long-Term Disability mean the period immediately following the end of your Expiration of Benefits leave for which LTD benefits are payable if you meet the requirements for a Disability or Total Disability at that time.

Monthly Covered Compensation means your annual basic wage rate as of September 1 of the prior calendar year, including the 12-month average of commissions and nondiscretionary bonus paid September 1 of the prior calendar year, divided by 12.

Net Credited Service (NCS) means a period of employment of an Employee in the service of the Company as defined by the AT&T Pension Benefit Plan – Wireless Program or the Cingular Wireless Pension Plan.

Pay
For purposes of determining STD benefits, means your annual basic wage rate as of the first day of your STD, including the 12-month average of commissions paid before your Date of Disability, but excluding bonuses, shift differentials, overtime, pay in lieu of PTO or other special payments.

No wage increase or other changes in Pay, other than those applicable following ratification of a new bargaining agreement, will be effective until you return to work on a part-time or full-time basis. A wage increase after a transitional return to work will be applicable for regular wages for time worked but will not be applicable to the calculation of Disability benefits.

For part-time Eligible Employees, pay is prorated based upon the number of regular scheduled hours per week, according to the payroll and worker classification records of the Employer.

For purposes of determining LTD and Supplemental LTD benefits, means your annual basic wage rate as of the first day of your STD, including 12-month average commissions paid before your Date of Disability and 24-month average nondiscretionary bonuses paid before your Date of Disability, but excluding shift differentials, discretionary bonuses, overtime, pay in lieu of PTO or other special payments.

For part-time Eligible Employees, pay is prorated based upon the number of regular scheduled hours per week, according to the payroll and worker classification records of the Employer.

Physician means a person licensed to practice medicine in the jurisdiction in which such services are performed or any other person whose services, according to applicable law, must be treated as Physician's services. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He or she must also be certified and/or registered if required by such jurisdiction. However, it is important to keep in mind that in order to

receive Appropriate Care and Treatment, the Physician's medical training and clinical specialty must be appropriate for treating the particular disability, e.g., a dermatologist cannot certify a disability for a heart attack. Practitioners other than medical doctors may be recognized as Physicians if required by applicable law. Any duly licensed mental health care professional will be deemed to be a Physician under the terms and conditions of this Plan.

You, your spouse, domestic partner, daughter, son, mother, father, sister, brother or other relatives are not included in the definition of Physician.

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

Plan Administrator means AT&T Inc. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Program, make findings of fact, determine the rights and status of participants and others under the Program and decide disputes under the Program. The Plan Administrator may delegate any of its duties or powers. To the extent permitted by law, such interpretations, findings, determinations and decisions shall be final and conclusive on all persons for all purposes of the Program.

Plan Sponsor means AT&T Inc.

Program means the AT&T Mobility Disability Benefits Program.

Total Disability
For STD purposes, means that due to an illness or injury you are unable to perform your Customary Job.

For LTD and Supplemental LTD purposes**,** means that after 24 months from your initial Date of Disability, you are continuously prevented by your Disability from engaging in any employment for which you are qualified or may reasonably become qualified for based on education, training or experience. As long as you remain Disabled based on this definition, you may receive LTD and Supplemental LTD benefits up to the maximum of age 65, unless you become disabled after age 60, in which case the maximum benefit duration is five years from your initial Date of Disability.

Waiting Period means the seven (7) consecutive calendar days following your Date of Disability. No STD benefits are payable during the Waiting Period.

OTHER PROGRAM INFORMATION

Amendment or Termination of the Program

The Program is adopted with the intention that it shall be continued for the benefit of present and future Employees of Participating Companies; however, the right is reserved by AT&T 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 shall 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 until such benefits would otherwise cease. This does not mean that an

Employee shall acquire a lifetime right to any Program benefit or 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 shall comply with all requirements of applicable law and shall 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 Program or Plan 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.

Misstatement of Fact

If there is a misstatement of any fact affecting your coverage under the Program, the actual facts will be used to determine the coverage or benefits due.

Limitations on Rights

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

Payment to Others

Disability benefits payable to an Eligible Employee unable to execute a proper receipt may be paid to a relative or other proper person, selected by the Claims Administrator, to use for the benefit of the Eligible Employee, and the receipt of such person shall be a sufficient discharge.

Right to Recovery of Overpayment of Benefits

If an overpayment of benefits is made by payroll or the Claims Administrator under the Program to, or on behalf of, you or your dependent(s), the Claims Administrator and/or payroll has the right to recoup the overpayment by any available means, including, but not limited to:

- Requiring you to return the overpayment upon request.
- Reducing or withholding any future benefit or wage payment made to or on behalf of you or your dependent(s).
- Sending the overpayment to a collections agency if you fail to return the overpayment after reasonable attempts have been made by the Claims Administrator to collect the overpayment.

This right to recover benefits overpayments also applies to payments from other sources for the same Disability, including amounts received from any third party. However, payments from this Program will not be reduced because of any benefits paid due to a military service disability that is unrelated to the Disability for which you receive benefits under the Program.

Failure to reimburse any overpayments made to you under the Program will result in suspension of benefits until reimbursement has occurred.

If an overpayment of STD, LTD or Supplemental LTD benefits results due to a periodic or lump sum award, for any reason for the same Disability, your pay or STD, LTD or Supplemental LTD benefits may be withheld or future payment may be reduced. If you do not satisfy the overpayment and return the funds to the Claims Administrator, the overpayment may be referred to a collection agency after reasonable attempts have been made to collect the overpayment.

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 before distribution to you.

Plan Information	
Program Name	AT&T Umbrella Benefit Plan No. 1 – AT&T Mobility Disability Benefits Program
Plan Sponsor and Plan Administrator (as defined by ERISA)	AT&T Inc. P.O. Box 29690 San Antonio, TX 78229 **210-351-3333**
Employer Identification Number	43-1301883
Plan Number	600
Type of Program	Employee Welfare Plan – Disability
Plan Year	Jan. 1 through Dec. 31
Plan Records	All Program records are kept on a calendar-year basis beginning on Jan. 1 and ending on Dec. 31.
Agent for Service of Legal Process	AT&T Inc. P.O. Box 29690 San Antonio, TX 78229 Service may also be made upon a Plan Trustee or the Plan Administrator.
Program Funding	Eligible Employees who elect Supplemental Long-Term Disability Benefits share in the cost of that portion of the Program. Program costs other than for Supplemental Long-Term Disability Benefits are paid by the Employer or through a Trust, which is established exclusively for approved Program purposes. No benefits provided under the Program are provided by insurance.

Table continues on next page

Plan Information	
AT&T Umbrella Plan No. 1 Trustees	Frost National Bank P.O. Box 2950 San Antonio, TX 78299 State Street Bank & Trust Company P.O. Box 1992 Boston, MA 02105-1992 Mellon Trust of New England, N.A. 135 Santilli Highway MZ#026-0038 Everett, MA 02149
Payment of Benefits	The Claims Administrator determines all claims for benefits under the Program. See the "Contact Information" section on Page 36 for information on how to contact the Claims Administrator. Benefits under the Program will be paid to you after the Claims Administrator has received and verified the necessary information concerning your Disability. The disability benefits are issued by the Claims Administrator. This payment represents a valid release of the benefits obligation under the Program
	Table continues on next page

Plan Information	
Type of Administration	The AT&T Umbrella Benefit Plan No. 1 and its component Programs are administered by AT&T. However, AT&T has contracted with third parties for certain functions associated with this Program: AT&T 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 AT&T Mobility Disability Benefits Program. The Claims Administrator has been delegated authority 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. This includes the authority to determine claims and appeals on these matters. AT&T manages enrollment and contributions for Supplemental Long-Term Disability Benefits under the Program on a contract basis with Hewitt Associates LLC (AT&T Benefits Center). The Plan Administrator (or, in matters delegated to third parties, the third party that has been so delegated) shall, to the maximum extent permitted by law, 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 shall not be overturned unless it is arbitrary and capricious. The fact that discretion is explicitly mentioned in certain sections of this document shall not be construed as implying that such discretion is absent from other sections. See the "Contact Information" section beginning on Page 36 for further information.
Collectively Bargained Plan	With respect to certain Eligible Employees, the Program is maintained pursuant to one or more collective bargaining agreements. A copy of the collective bargaining agreement may be obtained by Employees whose rights are governed by such collectively bargained agreement upon written request to the Program Administrator.

CONTACT INFORMATION

Review the following tables for contact information for the various Program Administrators and vendors and descriptions of certain administrative practices they utilize. Information for the following administrators and vendors is included:

AT&T Mobility Disability Benefits Program Claims Administrator
Nationwide Better Health
To initiate a claim for benefits under the Program, contact Nationwide Better Health. ☎ **866-453-2837** (866-4LEAVES) You may report a claim 24 hours a day, seven days a week Service associates are available Monday through Thursday from 8 a.m. to 7 p.m. and Friday from 8 a.m. to 5 p.m. Eastern time → You can report a claim, check the status of claim activity and confirm a return to work online through the Time Off Planning System (TOPS) at **www.topsabsence.com/cingularwireless.** Written claims for benefits under the Program may be sent to: Nationwide Better Health P.O. Box 183080 Columbus, OH 43218-3080 **877-389-1009** For overnight mail: Nationwide Better Health MR-07-15 215 N. Front St. Columbus, OH 43215 The address for appeals of denied disability claims is: Nationwide Better Health ATTN: AT&T Mobility Appeals Manager P.O. Box 183080 Columbus, OH 43218-3080 **877-389-1009**

Supplemental Long-Term Disability Benefits Enrollment Vendor
AT&T Benefits Center
To reach a service associate or access the Interactive Voice Response System (IVR) regarding eligibility for Supplemental Long-Term Disability Benefits under the Program, call the AT&T Benefits Center: ☎ **877-722-0020** ☎ **847-883-0866** (international) 🕐 Monday through Friday from 7 a.m. to 7 p.m. Central time, except some holidays 🕐 The IVR 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). To access the IVR or to speak to a service associate, 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.

Active Employee Address and Telephone Number Changes
It's important to keep your work and home addresses current because the majority of your benefits, payroll or similar information is sent to these addresses. Please include any room, cubicle or suite number that will help make mail-routing more efficient.
Home and **Mailing** addresses: • Go to **PeopleSoft** and navigate to **Self Service > Personal Information > Home and Mailing Addresses.** • Click the **Edit** button to the right of the address you want to update, **Home** or **Mailing**. • Enter your updated address information. • Enter the date the new address will take effect. • Click **Save**. (The Save Confirmation Page will display.) • Click **OK**, then log out of **PeopleSoft**. **Work** address: **Work** addresses must be updated by your manager through the **Request Location Change** task in **PeopleSoft Manager Self-Service**. *More information about updating **Home**, **Mailing** and **Work** addresses is available in **PeopleSoft Online Help**.*

Retired and Inactive Employee Home Address Changes
It's important to keep your home address up to date, because your benefits information is sent to this address.
Call the Fidelity Service Center to change your address. ☎ **800-416-2363** ☎ Dial your country's toll-free AT&T Direct access number, 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 when you call to speak to a service associate.

AT&T Benefits Intranet and Internet Access
Benefits section of HROneStop (active employees only) Go to the benefits section of HROneStop at **http://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.
Benefits section of access.att.com (employees and retirees from home) Go to the benefits section of **http://access.att.com** (AT&T's secure Internet site for employees and retirees) for benefits information at home, at any time: Just go to **http://access.att.com** and follow the login instructions.

State Disability Insurance
If your work location is in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, you may be eligible to receive benefits under that state's statutory benefit program in addition to this Program. Call the appropriate state agency.

California

Contact the local Employment Development Department (EDD) office to obtain an application for benefits. If you need help to determine your local office, call the EDD office in Sacramento, and that office will identify the number for your local EDD office.

☎ **800-480-3287**

California's statutory disability benefits are provided through the California State Disability Insurance Plan.

Hawaii

Hawaii's statutory disability benefits are provided through an insurance policy purchased from the Prudential Insurance Company.

☎ **800-842-1718**

New Jersey

Call the New Jersey Department of Labor Division of Temporary Disability Insurance (TDI).

☎ **609-292-6135**

New Jersey's statutory disability benefits are provided through the New Jersey Temporary Disability Benefits Trust Fund.

New York

New York's statutory disability benefits are provided through policies purchased from the Prudential Insurance Company.

☎ **800-842-1718**

Puerto Rico

Call the Puerto Rico Department of Insurance.

☎ **787-754-5012**

Puerto Rico's statutory disability benefits are provided through the Puerto Rico Non-Occupational Disability Insurance Program (SINOT by its Spanish acronym) since July 2005.

Rhode Island

Call the Temporary Disability Insurance Division, Rhode Island Department of Labor and Training.

☎ **401-462-8420**

Rhode Island's statutory disability benefits are provided through the Rhode Island Temporary Disability Insurance Program.