The Ameritech Comprehensive Health Care Plan (CHCP)

This booklet is your summary plan description (SPD) for the CHCP. However, as described further within, if you elect coverage with an alternative managed care product made available under the CHCP, you are subject to the benefits, terms and limitations of that particular option and not the coverage described in this SPD, unless specified otherwise. Upon election into a managed care option, you will automatically be sent additional information outlining the specific benefits, terms and limitations of the product you elect.

This SPD replaces the previous SPD in its entirety. Please file this SPD behind the appropriate tab in Your Benefits Binder.

Distribution

Distributed to bargained-for employees of ACP, AIS a.k.a. SBC Global Services, Inc., ASI-AIT, ILB, INB, MIB, NME, OHB, WIB and bargained-for retirees retired on or after 1/1/87. This SPD does not cover bargained-for employees of SBC Global Services, Inc., AIS IBEW 134 or AIS IBEW 58; Ameritech Communications, Inc.; Ameritech Publishing, Inc.; APIL Partners Partnership; and Southwestern Bell Communications Services, Inc.

NIN: 31911
Important Information

This booklet is your summary plan description (SPD) for the Ameritech Comprehensive Health Care Plan (CHCP) provisions of the Ameritech Non-Management Umbrella Welfare Benefit Plan, a program of the SBC Umbrella Plan No. 1. It is written for easy readability. Therefore, it may contain generalizations and colloquialisms rather than precise legal terms. Also, this document only summarizes benefits and individual situations may vary. In all cases, the official documents for the CHCP govern and are the final authority on the terms of the CHCP, and, if there are any discrepancies between the information in this SPD and the CHCP, the CHCP document will control. The SBC companies reserve the right to terminate or amend any and all of their employee benefit plans or programs, subject to any applicable collective bargaining agreement. Participation in the CHCP is neither a contract nor a guarantee of future employment. Please keep this SPD for future reference.
Table of Contents

<table>
<thead>
<tr>
<th>Using This Summary Plan Description (SPD)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>About This SPD</td>
<td>9</td>
</tr>
<tr>
<td>Introduction to the Ameritech Comprehensive Health Care Plan (CHCP)</td>
<td>9</td>
</tr>
<tr>
<td>How the CHCP Works</td>
<td>10</td>
</tr>
<tr>
<td>Eligibility for Participation in the CHCP</td>
<td>10</td>
</tr>
<tr>
<td>How and When You Enroll</td>
<td>11</td>
</tr>
<tr>
<td>If You Are an Active Employee</td>
<td>11</td>
</tr>
<tr>
<td>If You Are Retired</td>
<td>12</td>
</tr>
<tr>
<td>Annual Enrollment</td>
<td>12</td>
</tr>
<tr>
<td>Mid-Year Changes (Flexible Enrollment)</td>
<td>12</td>
</tr>
<tr>
<td>Prospectively</td>
<td>12</td>
</tr>
<tr>
<td>Post-Employment (Retirement) Medical Contributions</td>
<td>13</td>
</tr>
<tr>
<td>Enrollment in the HCN, PPO/Non-PPO, HMO or Other Alternative Managed Care Product</td>
<td>13</td>
</tr>
<tr>
<td>If You Move to a Mandatory ZIP Code Area</td>
<td>14</td>
</tr>
<tr>
<td>If Your Dependents Live Outside the HCN Area</td>
<td>14</td>
</tr>
<tr>
<td>If You Move From the HCN to a Non-Mandatory ZIP Code Area</td>
<td>15</td>
</tr>
<tr>
<td>If You Move From a Non-Mandatory ZIP Code Area to Another Non-Mandatory ZIP Code Area or Where Your HMO or Other Alternative Managed Care Product Option is Still Available</td>
<td>16</td>
</tr>
<tr>
<td>Levels of Coverage Available Under the CHCP</td>
<td>16</td>
</tr>
<tr>
<td>Annual Deductibles and Annual Out-of-Pocket Maximums Under the Plan</td>
<td>17</td>
</tr>
<tr>
<td>Table: Annual Deductibles and Annual Out-of-Pocket Maximums for the HCN and the PPO/Non-PPO</td>
<td>17</td>
</tr>
<tr>
<td>Prospective Enrollment</td>
<td>19</td>
</tr>
<tr>
<td>Pre-Existing Conditions</td>
<td>19</td>
</tr>
<tr>
<td>Precertification</td>
<td>19</td>
</tr>
<tr>
<td>Pre-Determination of Benefits</td>
<td>20</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>20</td>
</tr>
<tr>
<td>The Health Care Network (HCN)</td>
<td>20</td>
</tr>
<tr>
<td>Choosing a Primary Care Physician (PCP) Under the HCN</td>
<td>21</td>
</tr>
<tr>
<td>Using Network Providers</td>
<td>21</td>
</tr>
<tr>
<td>Using Non-Network Providers</td>
<td>22</td>
</tr>
<tr>
<td>How the Health Care Network (HCN) Works</td>
<td>23</td>
</tr>
<tr>
<td>When You Are Eligible</td>
<td>23</td>
</tr>
<tr>
<td>Receiving HCN Benefits</td>
<td>23</td>
</tr>
<tr>
<td>Network Benefits</td>
<td>23</td>
</tr>
<tr>
<td>Non-Network Precertification</td>
<td>24</td>
</tr>
<tr>
<td>Your HCN Benefits</td>
<td>25</td>
</tr>
<tr>
<td>Table: HCN Benefits</td>
<td>25</td>
</tr>
<tr>
<td>Table: HCN Plan Features</td>
<td>27</td>
</tr>
<tr>
<td>Further Details on Your HCN Benefits</td>
<td>29</td>
</tr>
<tr>
<td>Adult Physical Exams and Routine Gynecological Exams</td>
<td>29</td>
</tr>
<tr>
<td>Approved Home Care Agency and Hospice Care</td>
<td>29</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>29</td>
</tr>
<tr>
<td>Covered Hospital Expenses</td>
<td>29</td>
</tr>
<tr>
<td>Diagnostic X-Rays and Laboratory Tests</td>
<td>30</td>
</tr>
<tr>
<td>Disease Detection Tests</td>
<td>30</td>
</tr>
<tr>
<td>Hearing Test</td>
<td>31</td>
</tr>
</tbody>
</table>

Page 3

NIN: 31911
Hearing Aid Appliance .......................................................... 31
Organ Transplants ................................................................ 32
  Type A Procedure Coverage ............................................ 32
  Type B Procedure Coverage ............................................ 32
Outpatient Procedures .......................................................... 32
Pre-Admission Hospital Testing ................................................. 33
Second Opinions ................................................................ 33
Skilled Nursing Facility .......................................................... 33
Specialist Care ................................................................ 33
Surgical Procedures ............................................................... 34
Well-Child Care ................................................................ 34

The PPO/Non-PPO.................................................................. 34
  Using PPO Providers ......................................................... 35
  Using Non-PPO Providers .................................................. 35
  How the PPO/Non-PPO Works ...................................... 35
  When You Are Eligible .................................................... 36

Receiving PPO/Non-PPO Benefits .................................................. 36
Table: PPO/Non-PPO Benefits ........................................... 36
PPO/Non-PPO Benefits .......................................................... 37
Table: PPO/Non-PPO Plan Features ........................................... 37
PPO/Non-PPO Precertification .......................................................... 40

Further Details on Your PPO/Non-PPO Benefits .............................................. 40
  Adult Physical Exams and Routine Gynecological Exams ........ 40
  Approved Home Care Agency and Hospice Care ................. 40
  Disease Detection Tests .......................................................... 40
  Hearing Test ................................................................ 41
  Hearing Aid Appliance .......................................................... 41
  Organ Transplants ............................................................... 42
    Type A Procedure Coverage ............................................ 42
    Type B Procedure Coverage ............................................ 42
  Outpatient Procedures .......................................................... 42
  Second Opinions ............................................................... 42
  Skilled Nursing Facility .......................................................... 43
  Surgical Procedures ............................................................... 43
  Third Opinions ................................................................ 43
  Well-Child Care ................................................................ 43

Common Services or Supplies Covered by the Plan ........................................... 44
  Ambulance Service ............................................................... 44
  Approved Home Care Agency, Hospice Care and Skilled Nursing Facilities .......... 44
    Approved Home Care Agency ............................................ 44
    Hospice Care ................................................................ 44
    Skilled Nursing Facility .......................................................... 45
  Chiropractic Care ............................................................... 45
  Eligible Expenses .............................................................. 45
  Emergency Care ................................................................. 46
    Examples of an Emergency ............................................... 46
  Hospital Expenses ............................................................... 46
    Dental Hospitalization ...................................................... 47
    In-Hospital Physician or Specialist Visits .......................... 47
    Pre-Admission Hospital Testing ...................................... 47
    Weekend Hospital Admissions .......................................... 48
Maternity Benefits ................................................................. 48
Prospective Enrollment for a Newborn ...................................... 49
Medically Necessary .................................................................. 49
Not Medically Necessary ............................................................ 50
Organ Transplants .................................................................... 50
Type A Procedures ...................................................................... 50
Type B Procedures ...................................................................... 51
Outpatient Procedures ............................................................... 51
Surgical Procedures .................................................................... 52
Multiple Surgical Procedures .................................................... 52
Temporomandibular Joint (TMJ) ................................................ 53
Urgent Care Access ..................................................................... 53
COMMON SERVICES AND SUPPLIES THAT ARE NOT COVERED BY THE PLAN .................................................... 53
PRESCRIPTION DRUG COVERAGE ........................................... 55
Short-Term Prescriptions ............................................................ 55
Long-Term Prescriptions ........................................................... 56
MENTAL HEALTH/SUBSTANCE ABUSE (MH/SA) TREATMENT ................................................................. 56
HMO OR OTHER ALTERNATIVE MANAGED CARE PRODUCT ................................................................. 56
ELIGIBLE DEPENDENTS ............................................................ 58
IF YOU AND YOUR SPOUSE/RDP ARE BOTH EMPLOYED BY OR RETIRED FROM THE COMPANY ................................................. 59
CHANGE IN STATUS EVENTS .................................................... 59
How to Change Your Enrollment Due to a Change in Status Event ................................................................. 60
PROSPECTIVE ENROLLMENT .................................................... 60
NEW HIRE ELIGIBILITY ............................................................... 61
How To Enroll ............................................................................. 61
For Coverage to be Effective From Your Date of Hire ................. 61
For Coverage to be Effective on the First Day of the Month During Which You Complete Six Months of Service ................................................................. 61
Default Coverage .................................................................... 61
Prospective Enrollment ............................................................... 62
COST OF COVERAGE ................................................................. 62
Regular or Regular Limited Term Full-Time Employee .................. 62
Regular or Regular Limited Term Part-Time Employee ................. 62
WHEN YOUR COVERAGE ENDS .................................................. 63
Other Continuing Coverage Provisions ........................................ 64
IF YOU ARE ON AN APPROVED LEAVE OF ABSENCE OR ARE LAID OFF ................................................................. 64
Leave of Absence ...................................................................... 64
Layoff ....................................................................................... 64
IF YOU RETIRE ........................................................................ 65
IF YOU ARE ELIGIBLE FOR MEDICARE .................................................. 65
Medicare Part B Reimbursement ................................................ 65
If You Work Past the Age of 65 .................................................. 66
Long-Term Disability ................................................................. 66
If You Become Disabled Before the Age of 65 ......................... 66
End-Stage Renal Disease ........................................................... 66
The Plan is Integrated With Medicare ........................................ 66
Understanding Medicare ............................................................ 67
Qualifying for Medicare ............................................................ 67
Enrolling in Medicare Part A and Part B ..................................... 67
Assistance With Medicare Questions ......................................... 68
Time Periods for Appeals Determinations ................................................................. 127
  Pre-Service and Post-Service Claim Appeals ....................................................... 127
  Urgent Care Claim Appeals That Require Immediate Action ............................ 127
If You Want to Appeal a Claim Denied on the Basis of
  Eligibility to Enroll or to Participate in the CHCP ............................................. 127
Using This Summary Plan Description (SPD)

This SPD is a guide to using the Ameritech Comprehensive Health Care Plan (CHCP) which, effective Jan. 1, 2001, became a program component of the SBC Umbrella Plan No. 1. It is designed to help you find answers to your questions quickly.

Please read this SPD carefully and share it with your family members also covered under the CHCP. Understanding what the CHCP offers will help you take advantage of the benefits it provides and make the most of your total compensation package.

About This SPD

This is your SPD for the CHCP in effect as of Jan. 1, 2003. It includes any predecessor plan that was formally combined to create the Ameritech Non-Management Umbrella Plan as of Jan. 1, 1992. This SPD describes benefits for eligible bargained-for employees of such companies as Ameritech Corporation, Indiana Bell Telephone Company, Incorporated (INB), The Ohio Bell Telephone Company (OHB), Wisconsin Bell, Inc. (WIB), Michigan Bell Telephone Company (MIB), Illinois Bell Telephone Company (ILB), Ameritech New Media, Inc., Ameritech Services, Inc. (ASI), and SBC Global Services, Inc., who are covered by the collective bargaining agreements between the Communications Workers of America (CWA) District 4, IBEW 21, Ameritech Information Systems (AIS) IBEW 21 and IBEW 494 as well as Eligible Retirees who are covered under these collective bargaining agreements at the time of their retirement. There are some differences between the collective bargaining agreements, which are noted throughout this SPD.

This SPD does not cover bargained-for employees of SBC Global Services, Inc., AIS IBEW 134 or AIS IBEW 58; Ameritech Communications, Inc.; Ameritech Publishing, Inc.; APIL Partners Partnership; and Southwestern Bell Communications Services, Inc.

Introduction to the Ameritech Comprehensive Health Care Plan (CHCP)

Throughout this SPD, “Company” refers to the SBC Family of Companies (that is, the companies in the SBC tax-controlled group) and “Ameritech” refers to Ameritech Corporation. The terms “CHCP” and “Plan” are used throughout this SPD and are defined as provided below.

“CHCP” describes all of the health care coverage options available under the CHCP. These health care coverage options include:

- The Health Care Network (HCN)
- The Preferred Provider Organization (PPO/Non-PPO)
- A health maintenance organization (HMO), if available in your area
- Other alternative managed care product, if available in your area

“Plan” describes only the Company-offered health care coverage options available under the CHCP, i.e., the HCN and the PPO/Non-PPO coverage options. It does not include HMOs or other alternative managed care products.

Note: The definitions above, as well as definitions of other terms used in this SPD, such as “Annual Deductible”, “Copayment” “Coinsurance” and “Eligible Expenses”, are provided in the
How the CHCP Works

CHCP medical and surgical benefits are available through the HCN or the PPO/Non-PPO, an HMO or other alternative managed care product, if available in your area.

In addition to medical and surgical benefits, the Plan provides you with coverage for prescription drugs and mental health and substance abuse (MH/SA) treatment. To receive benefits from the Plan, you must meet an Annual Deductible, if applicable, and pay any required Copayments/Coinsurance. Once you reach your Annual Out-of-Pocket Maximum, Eligible Expenses are covered at 100 percent of the reasonable and customary fee (“R&C Fee”) established for the HCN or the negotiated PPO Fee for the service or supply, whichever is applicable. For additional information about these terms, refer to the “Definitions” section on Page 82.

Important: If you elect coverage with an HMO or other alternative managed care product option, instead of the HCN or PPO/Non-PPO option, your medical, surgical, prescription drug and MH/SA benefits, (and any additional benefits provided under the particular HMO or other alternative managed care product) will be subject to the benefits, terms and limitations of the particular HMO or other alternative managed care product. Therefore, before you enroll, it is important that you make sure you understand the types of benefits the HMO or other alternative managed care product provides, the cost of coverage and the terms and limitations of those benefits, including limitations on who may be covered. For example, some HMO’s impose limitations on the coverage of certain dependents that are covered under the Plan such as Registered Domestic Partners (RDPs) and Class II dependents.

Eligibility for Participation in the CHCP

If you are a Regular or Regular Limited Term full-time or part-time Employee, you are eligible to elect health care coverage under the CHCP for yourself and your eligible dependents beginning on your date of hire, provided you enroll within 31 days of the later of your hire date or the date you receive your enrollment materials from the Enrollment and Eligibility Vendor.

Note: Enrollments or changes to your coverage under the CHCP also may be made as described in the “Change in Status Events”, “Prospective Enrollment” and “New Hire Eligibility” sections on Pages 59-62.

Eligible former employees on a service or disability pension are also eligible for coverage along with their eligible dependents.

Note: Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for long-term disability and surviving spouse/RDP benefits as an active employee.

The Enrollment and Eligibility Vendor is responsible for handling eligibility for participation in the CHCP.
If you elect coverage under the CHCP, you will pay the full cost of coverage until you become eligible for Company contributions. Any contributions will be deducted from your paycheck, if active. If retired, any contributions will be deducted from your pension check, through direct debit or direct billed.

If you are a Regular or Regular Limited Term full-time or part-time Employee scheduled to work 25 hours or more per week, you are eligible for Company contributions toward your coverage for you and your eligible dependents, beginning the first day of the month in which you attain six months* of service with the Company, if, on that day, you are actively at work with the Company or receiving accident disability benefits under the Ameritech Sickness and Accident Disability Benefit Plan. In most cases the Company will pay the full cost of your coverage, however, if you enroll in an HMO or alternate managed care product, or your scheduled hours per week change, you may be required to make contributions.

If you do not enroll in the CHCP within the 31-day period and you are a Regular or Regular Limited Term full-time or part-time Employee, you will automatically be enrolled for Individual Coverage in either the HCN or PPO/Non-PPO option beginning the first day of the month in which you attain six months* of service with the Company, based on your home ZIP code, if, on that day, you are actively at work with the Company or receiving accident disability benefits under the Ameritech Sickness and Accident Disability Benefit Plan.

**Important:** Coverage for your eligible dependents is not automatic. If you want your dependents covered, you must enroll them.

*Refer to the “New Hire Eligibility” section on Page 61, for information on the temporary change in the time period for Company contribution eligibility. Also refer to the “Eligible Dependents” section on Page 58, and the “Cost of Coverage” section on Page 62 for additional information about eligibility for participation in the CHCP. For more information concerning how the HCN and PPO/Non-PPO work, refer to the “How the Health Care Network (HCN) Works” section on Page 23 and the “How the PPO/Non-PPO Works” section on Page 35.

**How and When You Enroll**

**If You Are an Active Employee**
You must enroll in the CHCP through the Enrollment and Eligibility Vendor. Your enrollment elections can be made:

- **During annual enrollment** — for coverage to be effective on the first day of the following calendar year
- **Within 31 days:**
  - **Of the later of your hire date or receipt of the enrollment materials from the Enrollment and Eligibility Vendor** — for coverage to be effective on your date of hire or the first of the month during which you complete six months* of service with the Company

*Refer to the “New Hire Eligibility” section on Page 61 for information on the temporary change in the time period for Company contribution eligibility.
• **Of the date you experience a change in status event** — for the change in coverage to be effective on the date the change in status event occurs

• **Prospectively** — for coverage to be effective the first of the month following enrollment

If you enroll within any of these timeframes, any required contributions will be deducted from your paycheck. For information on whether you may elect to have these contributions deducted on a *pre-tax* basis, refer to the SBC Flexible Spending Account Plan SPD.

*Note: Enrollments or changes to your coverage under the CHCP also may be made as described in the “Change in Status Events”, “Prospective Enrollment” and “New Hire Eligibility” sections on Pages 59-62.*

Refer to the “Enrollment and Eligibility Vendor” table on Page 114 for contact information.

**If You Are Retired**

*Annual Enrollment.* Unless you meet one of the exceptions listed below*, you are no longer required to take part in annual enrollment unless it becomes necessary because of a change in health plan availability. For example, if you are a participant in an HMO, Medicare Health Maintenance Organization (MHMO) or other alternative managed care product that will not be available during the next year, you will receive an annual enrollment packet that will include an enrollment worksheet and other information necessary to make an election. But, if the option you currently are enrolled in continues to be offered the next year, you will simply receive a Confirmation of Coverage showing your coverage and contributions* (if applicable) for the next year. At that time you can choose to keep the plan you are enrolled in — and do nothing — or you can contact the Enrollment and Eligibility Vendor to make a change.

*Mid-Year Changes (Flexible Enrollment)*. You are able to change anytime you want from the Company-offered medical plan to an HMO or other alternative managed care product, if available, or vice versa provided the HMO or other alternative managed care product administrator will permit mid-year changes without a change in status event. To make this change, you must contact the Enrollment and Eligibility Vendor. When you elect to change your coverage, the effective date of the new coverage will be the first of the second month following the date you request the change. For example, if you elect to change your coverage on Jan. 14, the effective date of your new coverage will be March 1.

*Prospectively.* For coverage to be effective the first of the month following enrollment.

*Flexible enrollment does not apply to retirees paying a contribution toward their medical coverage (except for contributions toward an HMO), active employees, long-term disability recipients, surviving spouse’s/RDP’s, COBRA participants, or former employees receiving a severance.*

You can also make changes to your choices *within* the Company-offered medical plan. For more information on enrollments or changes to your coverage under the CHCP refer to the “Change in Status Events” and “Prospective Enrollment” sections on Pages 59-62. For contact information refer to the “Contact Information” section on Page 104.
Important: If you wish to change your coverage to an HMO or other alternative managed care product, check with the HMO or other alternative managed care product administrator before initiating a change with the Enrollment and Eligibility Vendor to ensure the HMO or other alternative managed care product administrator will accept your enrollment. In addition, if you wish to enroll in a MHMO additional paperwork is required and MHMO required enrollment limitations, such as capacity limits, may apply. Please call the MHMO before electing coverage.

Post-Employment (Retirement) Medical Contributions
The level of Retiree Medical Assurance Program (RMAP) credits is $535 for non-Medicare participants and $230 for Medicare participants. An Eligible Retiree will only be charged or credited for a maximum of two participants, even if actual participants number more than two. Maximum CHCP charges and credits will be calculated using the Medicare eligibility status of the Eligible Retiree and the youngest of any Class I Dependents. However, no medical contributions will be required through Dec. 31, 2004, unless you are enrolled in an HMO or other alternative managed care product that requires a payment.

Note: Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for long-term disability and surviving spouse/RDP benefits as an active employee.

Enrollment in the HCN, PPO/Non-PPO, HMO or Other Alternative Managed Care Product
When you enroll in or become eligible for the CHCP, the Enrollment and Eligibility Vendor automatically will assign you a health care coverage option (either the HCN or PPO/Non-PPO), depending on if you reside in a mandatory ZIP code area*

You will be assigned the HCN option if you live in a mandatory ZIP code area*. You will be assigned the PPO/Non-PPO option if you do not live in a mandatory ZIP code area*. Your assigned coverage will be provided in your enrollment materials. Refer to “The Health Care Network (HCN)” section on Page 20 for additional details about mandatory ZIP code areas*.

If you are assigned the HCN option, you may stay covered under the HCN option, or instead elect to be covered under an HMO or other alternative managed care product option, if available in your area.

If you are assigned the PPO/Non-PPO option, you may stay covered under the PPO/Non-PPO option, or instead elect to be covered under the HCN option, an HMO or other alternative managed care product option, if available in your area.

If you elect to enroll in the PPO/Non-PPO option, you may elect to switch to the HCN during that calendar year. However, once enrolled in the HCN, you may not switch back to the PPO/Non-PPO for the remainder of that calendar year, unless you experience a change in status event, or are eligible for flexible enrollment. Refer to the “Change in Status Events” section on Page 59 and the “Mid-Year Changes (Flexible Enrollment)” section on Page 12 for additional details.

*There are no mandatory ZIP codes (i.e., enrollment in the HCN is voluntary), in Illinois, Indiana, Ohio, Michigan or Wisconsin, whether or not the criteria is met
as described in “The Health Care Network (HCN)” section on Page 20. This excludes employees covered by the collective bargaining agreement with IBEW 494.

If You Move to a Mandatory ZIP Code Area*
If you move from a PPO area to a HCN mandatory ZIP code area*, you will receive notice from the Enrollment and Eligibility Vendor. You will automatically be enrolled in the HCN or may choose an HMO or other alternative managed care product, if available in your area. If you do not enroll with the Enrollment and Eligibility Vendor and choose an HMO or other alternative managed care product, if available in your area, within 31 days of receipt of the notice, you will be automatically enrolled in HCN coverage. Whether you actively make an election or coverage is assigned as described, enrollment will be retroactive to the change of address date the Enrollment and Eligibility Vendor receives from Payroll.

The HCN requires you to choose a Primary Care Physician (PCP) when you enroll. If you do not, the Medical Claims Administrator will choose your PCP for you. You can change your PCP at any time. Any PCP changes will be effective immediately after you contact the Medical Claims Administrator and your selection has been processed, provided the PCP is accepting new patients.

Note: If you are not already a patient of the PCP you are choosing, always check with the PCP’s office to make sure the PCP is accepting new patients and is part of the Medical Claims Administrator’s network of providers before you select that PCP.

When you transfer from the PPO/Non-PPO option to the HCN, any expenses you have already paid during that calendar year will be applied as follows:

- The PPO/Non-PPO Annual Deductible will be credited to the HCN network Annual Out-of-Pocket Maximum.
- The PPO/Non-PPO Annual Out-of-Pocket expenses will be credited to the HCN non-network Annual Out-of-Pocket Maximum.

*There are no mandatory ZIP codes (i.e., enrollment in the HCN is voluntary), in Illinois, Indiana, Ohio, Michigan or Wisconsin, whether or not the criteria is met as described in “The Health Care Network (HCN)” section on Page 20. This excludes employees represented by IBEW 494.

If Your Dependents Live Outside the HCN Area
Dependents who live outside the network area, such as students away at school or family members living apart, may enroll in the HCN under the following guidelines:

- Dependents living outside your ZIP code area who use the HCN must enroll and select a network PCP. Network benefits will be paid if the dependent uses network providers and facilities. Once they enroll in the HCN, they will have to remain in the HCN for the calendar year, unless a change in status event occurs.
- If your dependents cannot use the HCN network due to distance, they can enroll in PPO/Non-PPO benefits if you notify the Enrollment and Eligibility Vendor. In this case:
• PPO/Non-PPO deductibles will accrue separately for your dependents and will not affect your HCN Annual Deductible (non-network) or Annual Out-of-Pocket expenses (network or non-network).

• Once your dependents are enrolled in the PPO/Non-PPO, you are not required to re-enroll them in this option each year.

Note: If you decide to enroll your dependent(s) in the HCN (for example, while they are home for the summer) you will not be able to re-enroll them in the PPO/Non-PPO until annual enrollment or unless you experience a change in status event or are retired and eligible for flexible enrollment. For additional information refer to the “Change in Status Events” section on Page 59.

If you are in the HCN and your dependent is in the PPO/Non-PPO, refer to the “Important Coverage Information” section on Page 104 for information about your Medical Claims Administrator.

Note: If you are not already a patient of the PCP you are choosing, always check with the PCP’s office to make sure the PCP is accepting new patients and is part of the Medical Claims Administrator’s network of providers before you select that PCP.

If You Move From the HCN to a Non-Mandatory ZIP Code Area
If you move to a ZIP code where the HCN is not mandatory*, you will receive a notice from the Enrollment and Eligibility Vendor indicating coverage under the PPO/Non-PPO and may elect to:

▪ Remain in the PPO/Non-PPO
▪ Re-enroll in the HCN
▪ Enroll in an HMO or other alternative managed care product, if available

Note: If you do not contact the Enrollment and Eligibility Vendor to make your election within 31 days of receipt of the notice, you will be enrolled in the PPO/Non-PPO. Whether you actively make an election or coverage is assigned as described above, enrollment will be retroactive to the change of address date the Enrollment and Eligibility Vendor receives from payroll.

If you change to the PPO/Non-PPO after moving to a non-HCN area and you have already contributed toward your HCN non-network Annual Deductible and Annual Out-of-Pocket Maximum, the amount(s) you paid will be applied as follows:

▪ The Network Annual Out-of-Pocket Expenses will be credited to the PPO/Non-PPO Annual Deductible.
▪ The Non-network Annual Deductible and Annual Out-of-Pocket Expenses will be credited to the PPO/Non-PPO Annual Out-of-Pocket Maximum.

For additional information about these terms, refer to the “Definitions” section on Page 82.
Important: If you are retired, on long-term disability, or are a surviving spouse/RDP, contact the Pension and Service Bridging Administrator to report your change of address. The Pension and Service Bridging Administrator will forward the new address to the Enrollment and Eligibility Vendor. The Enrollment and Eligibility Vendor will then send you the necessary election information. You will then complete your enrollment through the Enrollment and Eligibility Vendor as instructed.

If You Move From a Non-Mandatory ZIP Code* Area to Another Non-Mandatory ZIP Code Area or Where Your HMO or Other Alternative Managed Care Product Option is Still Available

If you are enrolled in the PPO/Non-PPO because you reside in a non-mandatory ZIP code area, HMO or other alternative managed care product and you move to another non-mandatory ZIP code area or where your HMO or other alternative managed care product is still available, you will not be sent a notice from the Enrollment and Eligibility Vendor and you will remain in your current election. However, if you are interested in determining if there are any additional choices available to you in the ZIP code you have just moved to, you must contact the Enrollment and Eligibility Vendor within 31 days of your move. If you make an election, enrollment will be retroactive to the change of address date the Enrollment and Eligibility Vendor receives from payroll.

*There are no mandatory ZIP codes (i.e., enrollment in the HCN is voluntary), in Illinois, Indiana, Ohio, Michigan or Wisconsin, whether or not the criteria is met as described in “The Health Care Network (HCN)” section on Page 20. This excludes employees covered by the collective bargaining agreement with IBEW 494.

Important: If you are retired, on long-term disability, or are a surviving spouse/RDP, contact the Pension and Service Bridging Administrator to report your change of address. The Pension and Service Bridging Administrator will forward your new address to the Enrollment and Eligibility Vendor. The Enrollment and Eligibility Vendor will then send you the necessary election information (if appropriate, as described within this section). You will then complete your enrollment through the Enrollment and Eligibility Vendor as instructed.

Enrollments or changes to your coverage under the CHCP also may be made as described in the “Change in Status Events”, “Prospective Enrollment” and “New Hire Eligibility” sections on Pages 59-62.

Levels of Coverage Available Under the CHCP

The CHCP offers the following three Levels of Coverage:

- **Individual** — You enroll only yourself
- **Individual plus one** — You enroll yourself and one eligible dependent (such as your spouse/RDP or an eligible child)
- **Individual plus two or more** — You enroll yourself and two or more eligible dependents (such as your spouse/RDP and an eligible child)

Refer to the “Eligible Dependents” section on Page 58 for information about who qualifies as your eligible dependent.
Annual Deductibles and Annual Out-of-Pocket Maximums Under the Plan

Before the non-network portion of the HCN or the PPO/Non-PPO begins to pay benefits, you must meet an Annual Deductible. In addition, both the HCN and PPO/Non-PPO have an Annual Out-of-Pocket Maximum which is the maximum amount of deductibles (if applicable) and Copayment/Coinsurance that you will pay out of your own pocket each year for Eligible Expenses. For additional information about these terms, refer to the “Definitions” section on Page 82.

The table below provides the HCN or PPO/Non-PPO Annual Deductible and Annual Out-of-Pocket Maximum by base pay and Level of Coverage.

| Annual Deductibles and Annual Out-of-Pocket Maximums for the HCN and the PPO/Non-PPO |
|---------------------------------|-----------------|-----------------|
|                                 | HCN             | PPO/Non-PPO     |
|                                 | NETWORK         | NON-NETWORK     |
| Annual Deductible¹ ²            | None            | $150 per Individual |
| Applicable if you are an:       |                 | $300 for Individual plus one or Individual plus two or more |
| ▪ Active employee, or           |                 |                 |
| ▪ If, on or before Dec. 31, 2000, you: |                 |                 |
|   ▪ Retired²,                   |                 |                 |
|   ▪ Were eligible for LTD benefits, or |                 |                 |
|   ▪ Were covered under surviving spouse/RDP provisions | | |
|                                 | $50,000 or less³ |                 |
| ▪ Annual Base Pay, Annual Pension, or Pension Equivalent if lump sum elected is: | $300 per Individual |
| ▪ $50,000 or less³             | $600 for Individual plus one or Individual plus two or more |
| ▪ $50,001 - $85,000³           |                  |
| ▪ $400 per Individual          |                  |
| ▪ $800 for Individual plus one or Individual plus two or more | |
| ▪ $85,001 or more³            |                  |
| ▪ $500 per Individual          |                  |
| ▪ $1,000 for Individual plus one or Individual plus two or more | |

¹Refer to the “Definitions” section on Page 82 for information concerning how the Annual Deductible and Annual Out-of-Pocket Maximum are met.
²Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for LTD and surviving spouse/RDP benefits as an active employee.
³These figures are based on your Annual Base Pay, Annual Pension or Pension Equivalent, whichever is applicable.
⁴A separate Annual Deductible and Annual Out-of-Pocket Maximum applies for prescription drug and MH/SA expenses.
<table>
<thead>
<tr>
<th><strong>ANNUAL DEDUCTIBLES AND ANNUAL OUT-OF-POCKET MAXIMUMS</strong></th>
<th><strong>HCN</strong></th>
<th><strong>PPO/Non-PPO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td><strong>Non-network</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>$300 per Individual</td>
</tr>
<tr>
<td>Applicable if, on or after Jan. 1, 2001, you:</td>
<td></td>
<td>$600 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td>▪ Retired²,</td>
<td></td>
<td>$300 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td>▪ Were eligible for LTD benefits, or</td>
<td></td>
<td>$300 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td>▪ Became covered under surviving spouse/RDP provisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$300 per Individual</td>
<td>$150 per Individual</td>
</tr>
<tr>
<td>Applicable if you are an:</td>
<td>$600 for Individual plus one or Individual plus two or more</td>
<td>$300 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td>▪ Active employee, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ If, on or before Dec. 31, 2000, you:</td>
<td></td>
<td>$650 per Individual</td>
</tr>
<tr>
<td>▪ Retired²,</td>
<td></td>
<td>$1,300 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td>▪ Were eligible for LTD benefits, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Were covered under surviving spouse/RDP provisions</td>
<td></td>
<td>Amounts stated <strong>include</strong> the Annual Deductible.</td>
</tr>
<tr>
<td><strong>Annual Base Pay, Annual Pension, or Pension Equivalent of lump sum elected is:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$50,000 or less³</td>
<td>$1,100 per Individual</td>
<td>$650 per Individual</td>
</tr>
<tr>
<td>▪ $2,200 for Individual plus one or Individual plus two or more</td>
<td>$1,300 for Individual plus one or Individual plus two or more</td>
<td></td>
</tr>
<tr>
<td>$50,001 - $85,000³</td>
<td>$1,400 per Individual</td>
<td>$1,700 per Individual</td>
</tr>
<tr>
<td>▪ $2,800 for Individual plus one or Individual plus two or more</td>
<td>$3,400 for Individual plus one or Individual plus two or more³</td>
<td></td>
</tr>
<tr>
<td>$85,001 or more³</td>
<td>$1,700 per Individual</td>
<td></td>
</tr>
<tr>
<td>▪ $3,400 for Individual plus one or Individual plus two or more³</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Amounts stated exclude the Annual Deductible.*
### Annual Deductibles and Annual Out-of-Pocket Maximums

**FOR THE HCN AND THE PPO/Non-PPO**

<table>
<thead>
<tr>
<th></th>
<th>HCN</th>
<th>PPO/Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NETWORK</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Annual Out-of-Pocket Maximum**<sup>1,4</sup> | ▪ $300 per Individual  
▪ $600 for Individual plus one or Individual plus two or more | ▪ $1,100 per Individual  
▪ $2,200 for Individual plus one or Individual plus two or more |
| Applicable if, on or after Jan. 1, 2001, you: |                  |            |
| ▪ Retired<sup>2</sup>, |                  | ▪ $650 per Individual  
▪ $1,300 for Individual plus one or Individual plus two or more |
| ▪ Were eligible for LTD benefits, or |                  | Amounts stated **exclude** the Annual Deductible.  
▪ Became covered under surviving spouse/RDP provisions |                 |
| ▪ Became covered under surviving spouse/RDP provisions |                  | Amounts stated **include** the Annual Deductible.  
▪ Became covered under surviving spouse/RDP provisions |

<sup>1</sup>Refer to the “Definitions” section on Page 82 for information concerning how the Annual Deductible and Annual Out-of-Pocket Maximum are met.

<sup>2</sup>Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for LTD and surviving spouse/RDP benefits as an active employee.

<sup>3</sup>These figures are based on your Annual Base Pay, Annual Pension or Pension Equivalent, whichever is applicable.

<sup>4</sup>A separate Annual Deductible and Annual Out-of-Pocket Maximum applies for prescription drug and MH/SA expenses.

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**Prospective Enrollment**

Prospective enrollment allows you to enroll yourself and any eligible dependents at any time into your health care benefit elections outside of the specified enrollment periods (for example, the period specified for new hires, annual enrollment or change in status event). When you do this, the effective date of the coverage will be the first day of the month following the date you request the change. Refer to the SBC Flexible Spending Account Plan SPD for more information on whether prospective enrollment will affect the amount of your pre-tax deduction, if any. **Note: Retirees should also refer to Page 12 for information about flexible enrollment.**

**Exception:** Once enrolled in the HCN, you may not switch to an HMO, or other alternative managed care product or the PPO/Non-PPO for the rest of the calendar year, unless you experience a change in status event or are eligible for flexible enrollment. Refer to Page 12 for information about flexible enrollment.

**Pre-Existing Conditions**

The Plan (i.e., the HCN and PPO/Non-PPO) does not include any special requirements relating to pre-existing conditions that must be met before the Plan will reimburse for Eligible Expenses.

**Precertification**

For some services you **must** call the applicable Claims Administrator for precertification of your treatment. If you do not, the Plan will pay $250 less than would otherwise be payable. And in the case of an Approved Home Care Agency, Hospice Care, Skilled Nursing, non-network Type A
Transplant Procedures and Mental Health and Substance Abuse, the Plan will not pay any benefits. Precertification helps you to be aware of whether or not you will be reimbursed for certain types of treatments before the treatments are provided. For more detailed information about precertification, refer to Appendix B on Page 80 and Appendix D on Page 122. For contact information, refer to the “Contact Information” section on Page 104. Precertification is not a determination of eligibility or a guarantee of payment.

Pre-Determination of Benefits
If you use a non-network or non-PPO provider you should ask your physician to submit a pre-determination of benefits* to the Medical Claims Administrator before the service is provided. The pre-determination of benefits will allow you and your physician to know if service is covered under your medical benefit plan before the service is provided, based on the procedure billing codes and other pertinent medical information the physician submits.

Once you receive the pre-determination of benefits from the Medical Claims Administrator you should compare the pre-determination of benefits with what the physician has quoted you for that same service to determine what portion of the bill will be your responsibility.

To request a pre-determination of benefits under your medical benefit plan, your physician should contact Customer Service at the toll-free telephone number on your medical ID card. You and your physician will receive notification of the coverage determination.

*A pre-determination is not a request for precertification. If your request for a pre-determination was submitted properly with all necessary information, you will receive written notice of the decision from the Medical Claims Administrator generally within 15 days of receipt.

Important: A pre-determination of benefits is valid for the 90-day period beginning on the date of the pre-determination of benefits notification. Procedures not performed within this period will require a new review. The final allowable charge determination will be made at the time the bill is submitted and will be based on the actual service provided. A pre-determination does not guarantee payment. Payment is subject to eligibility, coverage and all other plan provisions in place at the time medical care is administered.

Medical Necessity
The Plan will pay for a service or supply only if they are determined to be Medically Necessary by the applicable Claims Administrator under the terms of the Plan.

The Health Care Network (HCN)
The Health Care Network (HCN) is a group of hospitals, physicians, and other health care providers established by the Medical Claims Administrator. Your coverage in the HCN is based on whether you live in a mandatory ZIP code area*. A mandatory ZIP code area is one that meets the following criteria.

Within the ZIP code area, and within a five-mile radius of your home, there are:

- Two network internists/family physicians
- Two network pediatricians
Two network obstetricians or gynecologists
One hospital within 15 miles of your home ZIP code

If you live in a mandatory ZIP code area*, you are automatically assigned the HCN option (or you may elect to enroll in an HMO or other alternative managed care product option, if available in your area). If you do not live in a mandatory ZIP code area*, you may elect coverage either under the HCN option, the PPO/Non-PPO option, an HMO or other alternative managed care product, if available in your area.

*There are no mandatory ZIP codes (i.e., enrollment in the HCN is voluntary), in Illinois, Indiana, Ohio, Michigan or Wisconsin, whether or not the criteria is met as described in this section. This excludes employees covered by the collective bargaining agreement with IBEW 494.

Choosing a Primary Care Physician (PCP) Under the HCN
When you first enroll in the HCN, you and each covered dependent must select a Primary Care Physician (PCP) from the available network of providers.

- If you do not select a PCP, one will be selected for you by the Medical Claims Administrator. There are no limitations on how often you can select or change a PCP.
- If you are not already a patient of the PCP you wish to select, always check with the PCP to make sure the PCP is accepting new patients and is part of the Medical Claims Administrator’s network of providers before you select that PCP.

Any PCP changes will be effective immediately after you contact the Medical Claims Administrator and your selection has been processed, provided the PCP is accepting new patients.

You can choose to use network or non-network providers each time you receive health care services under the HCN. The benefit amount paid for:

- **Network providers** is based on the Network Provider Contracted Fees they have agreed to accept for their services.
- **Non-network providers** is based on the lesser of the provider’s fees or the R&C Fee.

*Note: If you choose to receive non-network services, you are responsible for any applicable deductibles, expenses above the R&C Fee, Copayment/Coinsurance and any ineligible expenses. Whether you use network or non-network providers, all services must be Medically Necessary in order to be considered an Eligible Expense payable under the Plan.

Using Network Providers
For network expenses, the network provider accepts payment based on a Network Provider Contracted Fee. Your only payment will be the applicable Copayment, if any. When you use network services, the Plan will pay up to the Network Provider Contracted Fee for the service, after you pay any necessary Copayments. You are not responsible for any amounts over the Network Provider Contracted Fee.

Once you reach the Annual Out-of-Pocket Maximum, you will not be required to pay any additional Copayments/Coinsurance for the remainder of the calendar year. Refer to the
“Annual Deductible and Annual Out-of-Pocket Maximums for the HCN and the PPO/Non-PPO” table on Page 17 for additional information and the “Definitions” section on Page 82 for information on how the Annual Out-of-Pocket Maximum is met.

No single covered family member will pay more than the Individual Annual Out-of-Pocket Maximum. Once two covered family members have each met the Individual Annual Out-of-Pocket Maximum, the Individual plus one or Individual plus two or more Annual Out-of-Pocket Maximum will be satisfied for all covered family members for that calendar year.

When you receive treatment from your PCP or another HCN network provider, the provider will file your claim. Your HCN level of benefits depends on whether you receive network or non-network services. You may need to file a claim to receive reimbursement if non-network services are used. All services must be Medically Necessary in order to be considered an Eligible Expense payable under the Plan. Refer to the “Definitions” section on Page 82, the “Common Services or Supplies Covered by the Plan” section on Page 44 and the “Contact Information” section on Page 104 for further information.

Refer to the “Annual Deductibles and Annual Out-of-Pocket Maximums for the HCN and the PPO/Non-PPO” table on Page 17 for additional information and the “Definitions” section on Page 82 for information on how the Annual Out-of-Pocket Maximum is met.

**Using Non-Network Providers**

For non-network expenses, the Plan reimburses at 75 percent of the R&C Fee of your Eligible Expenses, with exceptions noted in this SPD, after you meet the Annual Deductible.

When using non-network services, you must meet an Annual Deductible as well as pay any Copayments/Coinsurance and ineligible expenses. Your out-of-pocket expenses will be higher when you use non-network services, since the Plan will pay benefits only up to 75 percent of Eligible Expenses up to the applicable R&C Fee (with a few exceptions) and non-network providers may choose to charge you more. After reaching your Annual Out-of-Pocket Maximum, which is based on your Annual Base Pay, Annual Pension, or Pension Equivalent, whichever is applicable, Eligible Expenses incurred using non-network providers will be covered at 100 percent of Eligible Expenses up to the applicable R&C Fee for the remainder of the calendar year and you will not pay any additional Copayment/Coinsurance. However, any charges above the R&C Fee or ineligible expenses will be your responsibility and do not apply to the Annual Deductible.

If you or a dependent use non-network providers for health care services, you may have to file a claim and submit it, along with an itemized bill, to the Medical Claims Administrator.

Refer to the “Annual Deductibles and Annual Out-of-Pocket Maximums for the HCN and the PPO/Non-PPO” table on Page 17 for additional information and to the “Definitions” section on Page 82 for information on how the Annual Deductible and Annual Out-of-Pocket Maximum are met.

*Note: If you choose to use non-network providers or receive non-network services, you are responsible for any applicable deductibles, expenses above the R&C Fee, and any other ineligible expenses. If you do not obtain precertification when required before receiving non-network services, having a procedure done or obtaining supplies, the Plan will pay $250 less than would otherwise have been paid, or, in the case of an Approved Home Care Agency, Hospice Care, Skilled Nursing and non-network Type A Transplant Procedures, the Plan will not*
pay any benefits. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

How the Health Care Network (HCN) Works
The Health Care Network (HCN) is a network of physicians, hospitals, and other health care providers who have agreed, under a contract with the Medical Claims Administrator, to accept set fees for medical services.

If you participate in the HCN, you and your eligible dependents can choose to receive network or non-network services each time you seek care.

When You Are Eligible
You will participate in the HCN if you live in an area where a network is available and therefore mandatory, based on your ZIP code*. If you do not live in a mandatory ZIP code area you and your eligible dependents will receive coverage under the PPO/Non-PPO. No matter where you live, you may voluntarily enroll in the HCN, an HMO or other alternative managed care product, if available in your area.

*There are no mandatory ZIP codes (i.e., enrollment in the HCN is voluntary), in Illinois, Indiana, Ohio, Michigan or Wisconsin, whether or not the criteria is met as described on Page 21. This excludes employees covered by the collective bargaining agreement with IBEW 494.

Receiving HCN Benefits
Your HCN benefits are based on:

- Whether you choose to receive network or non-network services
- The R&C Fees and eligible hospital expenses determined by the Medical Claims Administrator

All services must be Medically Necessary in order to be considered an Eligible Expense payable under the Plan.

Network Benefits
Network services are provided by your network PCP or other network providers. When you receive network benefits, you will:

- Not have an Annual Deductible
- Pay a maximum of $300 per Individual or $600 for Individual plus one or Individual plus two or more of Eligible Expenses out of your pocket each calendar year
- Pay the following Copayments:
  - $5 for well-child care
  - $10 for physician office visits
• $60 for hospital admission and related expenses and outpatient surgery or other procedures
• $25 for emergency room treatment (if admitted, the $25 Copayment will apply to the $60 admission Copayment)
• $25 for urgent care (depending on the facility and the treatment the Copayment may be less)

It’s Your Choice ... You can choose to receive network or non-network services each time you visit a provider. However, remember that network care generally requires less out-of-pocket expenses and your provider will file your claim for benefits.

DID YOU KNOW? ... It is your responsibility to select a network provider or facility before you receive medical treatment? If you choose to go to a provider or facility without a referral* from your PCP and inadvertently use a non-network provider or facility, you will be responsible for any ineligible expenses under the non-network provisions of the Plan and your benefit will be paid at the non-network level. So be sure to verify ahead of time that the provider or facility is a network provider by contacting the Medical Claims Administrator and asking the provider’s office before receiving medical treatment. If your PCP inadvertently refers you to a non-network provider or facility without precertifying, your benefits will be paid at the network level.

*No paper referral is required.

Non-Network Precertification
If you seek care from a non-network provider without receiving precertification when required, any reimbursement you receive will be paid at the non-network level of benefits and in some cases less a $250 penalty, (after meeting your Annual Deductible and paying any Copayment/Coinsurance, expenses above the R&C Fee, and ineligible expenses). In the case of an Approved Home Care Agency, Hospice Care, Skilled Nursing and non-network Type A Transplant Procedures, the Plan will not pay any benefits. For additional information about these terms, refer to the “Definitions” section on Page 82. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information. Precertification is not a determination of eligibility for benefits or participation in the Plan.
## Your HCN Benefits

The table below also lists the HCN Annual Deductible and Annual Out-of-Pocket Maximum by Annual Base Pay, Annual Pension or Pension Equivalent (if a lump sum is elected) and the Level of Coverage.

<table>
<thead>
<tr>
<th>HCN Benefits</th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong>&lt;sup&gt;1, 4&lt;/sup&gt;</td>
<td>None</td>
<td>If Annual Base Pay, Annual Pension, or Pension Equivalent if lump sum elected is:</td>
</tr>
<tr>
<td>Applicable if you are an:</td>
<td></td>
<td>- $50,000 or less&lt;sup&gt;3&lt;/sup&gt;:</td>
</tr>
<tr>
<td>▪ Active employee, or</td>
<td></td>
<td>■ $300 per Individual</td>
</tr>
<tr>
<td>▪ If, on or before Dec. 31, 2000, you:</td>
<td></td>
<td>■ $600 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td>■ Retired&lt;sup&gt;2&lt;/sup&gt;,</td>
<td></td>
<td>- $50,001 - $85,000&lt;sup&gt;3&lt;/sup&gt;:</td>
</tr>
<tr>
<td>■ Were eligible for LTD benefits, or</td>
<td></td>
<td>■ $400 per Individual</td>
</tr>
<tr>
<td>■ Were covered under surviving spouse/RDP provisions</td>
<td></td>
<td>■ $800 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- $85,001 or more&lt;sup&gt;3&lt;/sup&gt;:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ $500 per Individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ $1,000 for Individual plus one or Individual plus two or more</td>
</tr>
</tbody>
</table>

If, on or after Jan. 1, 2001, you:

- Retired<sup>2</sup>,
- Were eligible for LTD benefits, or
- Became covered under surviving spouse/RDP provisions

| Annual Deductible<sup>1, 4</sup> | None | $300 per Individual |
| | | $600 for Individual plus one or Individual plus two or more<sup>3</sup> |

<sup>1</sup>Refer to the “Definitions” section on Page 82 for information concerning how the Annual Deductible and Annual Out-of-Pocket Maximum are met.

<sup>2</sup>Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for LTD and surviving spouse/RDP benefits as an active employee.

<sup>3</sup>These figures are based on your Annual Base Pay, Annual Pension or Pension Equivalent, whichever is applicable.

<sup>4</sup>A separate Annual Deductible and Annual Out-of-Pocket Maximum applies for prescription drug and MH/SA expenses.
<table>
<thead>
<tr>
<th>HCN BENEFITS</th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
</table>
| **Annual Out-of-Pocket Maximum**¹, ⁴ | $300 per Individual  
$600 for Individual plus one or Individual plus two or more | If Annual Base Pay, Annual Pension, or Pension Equivalent if lump sum elected is:  
- $50,000 or less³  
  - $1,100 per Individual  
  - $2,200 for Individual plus one or Individual plus two or more  
- $50,001 - $85,000³  
  - $1,400 per Individual  
  - $2,800 for Individual plus one or Individual plus two or more  
- $85,001 or more³  
  - $1,700 per Individual  
  - $3,400 for Individual plus one or Individual plus two or more |
| Applicable if you are an:  
- Active employee, or  
- If, on or before Dec. 31, 2000, you:  
  - Retired²,  
  - Were eligible for LTD benefits, or  
  - Were covered under surviving spouse/RDP provisions | 
| **Annual Out-of-Pocket Maximum**¹, ⁴ | $300 per Individual  
$600 for Individual plus one or Individual plus two or more | $1,100 per Individual  
$2,200 for Individual plus one or Individual plus two or more |
| Applicable if, on or after Jan. 1, 2001, you:  
- Retired²,  
- Were eligible for LTD benefits, or  
- Became covered under surviving spouse/RDP provisions | 
| **Maximum Lifetime Benefit**  
(excludes MH/SA treatment and prescription drug costs) | None | None for active employees; $500,000 maximum lifetime benefit limit applies to each Eligible Retiree and each of his eligible dependent(s) |

¹Refer to the “Definitions” section on Page 82 for information concerning how the Annual Deductible and Annual Out-of-Pocket Maximum are met.

²Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for LTD and surviving spouse/RDP benefits as an active employee.

³These figures are based on your Annual Base Pay, Annual Pension or Pension Equivalent, whichever is applicable.

⁴A separate Annual Deductible and Annual Out-of-Pocket Maximum applies for prescription drug and MH/SA expenses.

As explained previously, your HCN benefits depend on whether you receive network or non-network services. You may need to file a claim to receive reimbursement when non-network services are used. All services must be Medically Necessary in order to be considered an
Eligible Expense payable under the HCN. Refer to the “Definitions” section on Page 82 and “Common Services or Supplies Covered by the Plan” on Page 44 for further information.

<table>
<thead>
<tr>
<th>HCN PLAN FEATURE</th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization/Ambulatory Surgical Center</td>
<td>$60 Copayment per admission, then at 100% of Eligible Expenses</td>
<td>75% of Eligible Expenses, after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Precertification required</em></td>
</tr>
<tr>
<td>Physician/Specialist Office Visit</td>
<td>$10 Copayment per visit, then at 100% of Eligible Expenses</td>
<td>75% of Eligible Expenses, after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Precertification not required</em></td>
</tr>
<tr>
<td>Wellness Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Care</td>
<td>$5 Copayment per visit, then at 100% of Eligible Expenses</td>
<td>After deductible, ages 0-12, $150 per year; age 13-18, four visits total, $50 maximum per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Precertification not required</em></td>
</tr>
<tr>
<td>Wellness Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Physical Exam (age 19 and over)</td>
<td>$10 Copayment per visit, then at 100% of Eligible Expenses</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Gynecological Exam</td>
<td>$10 Copayment per visit, then at 100% of Eligible Expenses</td>
<td>Not covered; Pap test covered at 100% of billed charges, with no deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Precertification not required</em></td>
</tr>
<tr>
<td>Wellness Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Detection Tests (subject to frequency limits noted on Page 30)</td>
<td>$10 Copayment per visit, then at 100% of Eligible Expenses</td>
<td>$75 annual benefit, including office visit (for pap test and mammogram), no deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Precertification not required</em></td>
</tr>
<tr>
<td>Second Opinions</td>
<td></td>
<td>100% of Eligible Expenses covered, no deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Precertification required</em></td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$25 Copayment, then at 100% of Eligible Expenses</td>
<td>$25 Copayment, then at 75% of Eligible Expenses, after deductible (depending on the facility and the treatment the Copayment may be less); if determined to be an emergency then the benefit will be paid as emergency treatment</td>
</tr>
<tr>
<td></td>
<td>(depending on the facility and the treatment the Copayment may be less)</td>
<td><em>Precertification not required</em></td>
</tr>
<tr>
<td><strong>HCN PLAN FEATURE</strong></td>
<td><strong>NETWORK</strong></td>
<td><strong>NON-NETWORK</strong></td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong></td>
<td>$25 Copayment, applied to $60 hospital Copayment if admitted; then at 100% of Eligible Expenses, no deductible</td>
<td>$25 Copayment, applied to $60 hospital Copayment if admitted, then at 100% of Eligible Expenses, no deductible. Precertification not required.</td>
</tr>
<tr>
<td><strong>Emergency Treatment Provided in a Physician’s Office</strong></td>
<td>$10 Copayment per visit; 100% of Eligible Expenses covered thereafter</td>
<td>$10 Copayment per visit; 100% of Eligible Expenses covered thereafter, no deductible. Precertification not required.</td>
</tr>
<tr>
<td><strong>Organ Transplant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: For all Type A non-network procedures, benefits will be paid only if precertification was received. All Type A &amp; B procedures must be performed at an Approved Transplant Facility.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Type A</strong></td>
<td><strong>Type B</strong></td>
</tr>
<tr>
<td></td>
<td>Cornea, kidney, heart valve, tissue, and bone marrow transplants</td>
<td>Heart, liver, heart-lung, pancreas-kidney, pancreas, isolated or bilateral organ transplants</td>
</tr>
<tr>
<td></td>
<td>$60 Copayment per admission then 100% of Eligible Expenses covered if performed at an Approved Transplant Facility</td>
<td>$60 Copayment per admission then 100% of Eligible Expenses covered if performed at an Approved Transplant Facility</td>
</tr>
<tr>
<td></td>
<td>75% of Eligible Expenses after deductible, if performed at an Approved Transplant Facility</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Approved Home Care Agency, Hospice Care, &amp; Skilled Nursing</strong></td>
<td>100% of Eligible Expenses (with PCP coordination)</td>
<td>75% of Eligible Expenses, after deductible. Precertification required, otherwise no benefits will be paid.</td>
</tr>
<tr>
<td><strong>Diagnostic X-Rays &amp; Laboratory Tests</strong></td>
<td>100% of Eligible Expenses</td>
<td>75% of Eligible Expenses after deductible. Precertification not required.</td>
</tr>
<tr>
<td><strong>Pre-Admission Testing</strong></td>
<td>100% of Eligible Expenses (with network provider coordination)</td>
<td>75% of Eligible Expenses, after deductible. Precertification required.</td>
</tr>
<tr>
<td><strong>Chiropractic Treatment Provided By Chiropractor or Osteopath</strong></td>
<td>100% of Eligible Expenses; after $10 Copayment per visit</td>
<td>75% of Eligible Expenses, up to $200 per year after deductible. Precertification not required.</td>
</tr>
<tr>
<td><strong>Hearing Test and Hearing Aid Appliance</strong></td>
<td><strong>Test:</strong> 100% of Eligible Expenses, after $10 Copayment. <strong>Appliance:</strong> based on a rolling 36-month period, up to a $1,000 maximum</td>
<td><strong>Test:</strong> 75% of Eligible Expenses after deductible. <strong>Appliance:</strong> based on a rolling 36-month period, up to a $1,000 maximum.</td>
</tr>
</tbody>
</table>
Further Details on Your HCN Benefits

Adult Physical Exams and Routine Gynecological Exams

Network.

- **Adult Physical Exams:** When you see your PCP for an adult physical exam, you will pay a $10 Copayment for the visit. The Plan will cover 100 percent of Eligible Expenses. Adult physical exams include periodic office visits for checkups and related lab tests and X-rays, if you are age 19 or over.

- **Routine Gynecological Exams:** Routine gynecological exams are provided by your network obstetrician/gynecologist and are for females age 13 and over. You will pay a $10 Copayment for the visit. The Plan will cover 100 percent of Eligible Expenses.

**Non-network.** Adult physical exams and routine gynecological exams are **not** covered. Pap tests are covered at 100 percent of the billed charges and are not subject to the Annual Deductible.

Approved Home Care Agency and Hospice Care

Network. When you coordinate your care with your PCP for home health or Hospice Care, the Plan will cover 100 percent of Eligible Expenses.

**Non-network.** The Plan will cover your Eligible Expenses for an Approved Home Care Agency or Hospice Care at 75 percent of the R&C Fee, after you meet the deductible, if you have obtained precertification. **If you have not received precertification, no benefits will be paid.**

Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Chiropractic Care

Network. If your care is coordinated by your PCP or a network specialist, the Plan will cover your chiropractic treatment at 100 percent of Eligible Expenses, after you pay a $10 Copayment.

**Non-network.** Eligible Expenses for chiropractic care will be covered at 75 percent of the R&C Fee, up to an annual maximum of $200 after any applicable deductible.

Covered Hospital Expenses

As with all expenses, hospital expenses must be determined by the Medical Claims Administrator to be Eligible Expenses covered by the HCN. For a list of covered hospital expenses, refer to the “Hospital Expenses” section on Page 46.
**Network.** When your PCP or a network specialist admits you to a network hospital, you receive network benefits. After you pay a $60 Copayment per admission, all Eligible Expenses for covered services provided during your stay, including intensive care, semi-private room and board, diagnostic tests, and physician’s visits are covered at 100 percent. You do not need to call for precertification.

**Non-network.** If you are admitted by a non-network provider to either a network or non-network hospital, your Eligible Expenses will be covered if you notify the Medical Claims Administrator and obtain precertification. Otherwise the Plan will pay $250 less than would otherwise be payable. After you satisfy your Annual Deductible, Eligible Expenses are covered at 75 percent. You will pay the remaining 25 percent in addition to any other ineligible expenses.

Refer to *Appendix B* on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to *Appendix D* on Page 122 for additional precertification information.

**Diagnostic X-Rays and Laboratory Tests**

**Network.** Eligible Expenses will be covered at 100 percent if your PCP or a network specialist recommends diagnostic X-rays or laboratory tests that are consistent with your illness or symptoms.

**Non-network.** If you receive X-rays or laboratory tests recommended by a non-network physician, the Plan will pay 75 percent of Eligible Expenses after any applicable deductible.

**Disease Detection Tests**

Disease detection tests include:

- Mammograms (every other year for ages 40-49 and every year for ages 50 and over)
- Fecal occult blood tests (once annually)
- Total serum cholesterol tests (once annually)
- Blood glucose tests for diabetes (once annually)
- Sigmoidoscopies (once every three years for ages 50-59 and every year for ages 60 and over)
- Pap test

**Network.** The Plan will cover any disease detection tests scheduled by your PCP as well as related physician expenses at 100 percent of Eligible Expenses (after a $10 Copayment if a physician’s visit is included).

**Non-network.** The Plan will pay up to a $75 annual benefit of Eligible Expenses (including related physician’s visit with a pap test or mammogram), which is not subject to the Annual Deductible. However, pap tests will be covered at 100 percent of billed charges and are not part of the $75 annual benefit.
Hearing Test

**Network.** The Plan will cover 100 percent of Eligible Expenses for the office visit and hearing test, after a $10 Copayment.

**Non-network.** The Plan will pay 75 percent of Eligible Expenses, after the deductible is met for the office visit and hearing test.

If your network or non-network physician refers you to an audiologist for a hearing test, the reimbursement for the test will be made at the network level of benefits if it was a network provider that referred you to an audiologist. If it was a non-network provider that referred you to an audiologist, the test will be reimbursed at the non-network level of benefits.

If your physician’s office does not submit a bill/claim for the hearing test, you must submit, along with your bill/claim, either a prescription or a signed letter from your physician on his or her letterhead that refers you to an audiologist for testing and/or establishes Medical Necessity for you to purchase a hearing aid appliance.

**Important:** The same prescription or letter signed by the physician on the physician’s letterhead can be used when submitting the claim for the hearing test/exam as well as for the hearing aid appliance. If you submit a claim without the appropriate documentation, the claim will not be paid.

*Note: The office visit and/or test to determine hearing loss is covered and is not subject to the $1,000 cap for the hearing aid appliance.*

Hearing Aid Appliance

**If You Purchase a Hearing Aid Appliance Through Your Physician.** If your physician’s office submits the bill/claim for a hearing aid appliance purchase, the hearing aid appliance reimbursement will be payable up to $1,000 of billed charges in each rolling 36-month period, which begins on the date of purchase.

**If You Purchase a Hearing Aid Appliance From a Source Other Than Your Physician.** If your physician’s office does not submit a bill/claim for you hearing aid appliance purchase, you must submit, along with your bill/claim, either a prescription or a signed letter from your physician on his or her letterhead that refers you to an audiologist for testing and/or establishes Medical Necessity for you to purchase a hearing aid appliance. The hearing aid appliance reimbursement will be payable up to $1,000 of billed charges in each rolling 36-month period, which begins on the date of purchase.

**Important:** The same prescription or letter signed by the physician on the physician’s letterhead can be used when submitting the claim for the hearing test/exam as well as for the hearing aid appliance. If you submit a claim without the appropriate documentation, the claim will not be paid.

These procedures have been designed because there currently are no network audiologists or hearing aid appliance providers in the Plan and the R&C Fee is not calculated for the hearing aid appliance. If either becomes available, these procedures will be revised, if appropriate.
Note: The Plan will cover the first hearing aid following illness or injury, and it is NOT subject to the $1,000 cap.

Organ Transplants

Important: All Type A & B procedures must be performed at an Approved Transplant Facility. In addition, all Type A non-network procedures must be precertified. Otherwise no benefits will be paid. Type B Procedures performed by a non-network provider and/or at a non-network facility are not covered by the Plan.

The following information refers specifically to the HCN provisions of the CHCP. More Plan information on organ transplants is included in the “Common Services or Supplies Covered by the Plan” section on Page 44.

Type A Procedure Coverage

Network. The Plan will cover Type A procedures when they are coordinated by your network physician and performed at a network Approved Transplant Facility. The Plan will cover 100 percent of Eligible Expenses after you pay a $60 Copayment per admission.

Non-network. The Plan will cover Type A procedures at an Approved Transplant Facility at 75 percent of Eligible Expenses after you meet your Annual Deductible. Precertification is required; otherwise the Plan will not pay any benefits. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Type B Procedure Coverage

Network. The HCN will cover Type B procedures when they are coordinated by your network physician and performed by a network physician at a network Approved Transplant Facility. The HCN will cover 100 percent of Eligible Expenses after you pay a $60 Copayment per admission.

Non-network. Type B procedures performed by a non-network physician and/or at a non-network facility are not covered by the HCN.

Outpatient Procedures

Network. You pay a $60 Copayment for outpatient procedures performed by your PCP or a network specialist, and all remaining charges are covered at 100 percent of Eligible Expenses. The $60 Copayment does not apply for any network surgery performed in a physician’s office or if the procedure is included in the outpatient procedure list provided in Appendix A on Page 79.

Non-network. If a non-network provider performs your outpatient procedures, the Plan will pay both the facility and the non-network provider at 75 percent of Eligible Expenses after you meet the Annual Deductible. Precertification is required. Otherwise the Plan will pay $250 less than would otherwise be payable. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification and to the “Non-Network Precertification” section on Page 24 for more details. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Note: For some services you must call for precertification of your treatment; otherwise the Plan will pay $250 less than would otherwise be payable or in some cases the Plan will not pay benefits at all. Precertification helps you to be aware of whether or not, in the case of an Approved Home Care Agency, Hospice Care, Skilled Nursing and non-network Type A Transplant
Procedures, the Plan will pay any benefits. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Pre-Admission Hospital Testing
**Network.** Pre-admission hospital testing scheduled by your PCP or network specialist is covered at 100 percent of Eligible Expenses.

**Non-network.** Pre-admission hospital testing scheduled by a non-network provider is covered at 75 percent of Eligible Expenses, after deductible, with precertification. Otherwise the Plan will pay $250 less than would otherwise be payable, after you meet your Annual Deductible. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Second Opinions
**Network.** If you would like a second opinion, the Plan will cover your visit at 100 percent of Eligible Expenses if you see a network physician and pay a $10 Copayment.

**Non-network.** If you obtain precertification, your second opinion will be covered at 100 percent of Eligible Expenses, with no deductible. If you do not obtain precertification, the second opinion is still covered, but at 75 percent of Eligible Expenses after you meet your Annual Deductible. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Skilled Nursing Facility
**Network.** After paying a $60 Copayment, the Plan will cover your Eligible Expenses at 100 percent. The Copayment does not apply if you are transferred to the facility directly from the hospital. Care must be coordinated with your PCP.

**Non-network.** The Plan will cover your Eligible Expenses up to 75 percent of the R&C Fee, after you meet the deductible, if you have received precertification. **If you have not received precertification, no benefits will be paid.** Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Specialist Care
**Network.** To receive network benefits, you and your PCP should work together to manage your health care. Your PCP is not required to obtain a referral from the Medical Claims Administrator to refer you to another network specialist who is appropriate for your condition.

Each time you see a network specialist and receive network benefits, you pay a $10 Copayment. If you are receiving continuing treatment, for example, allergy shots, and you are receiving them from a nurse in the specialist’s office, then the Copayment may be waived. Contact the Medical Claims Administrator for more information.
If your network provider needs to refer you to a non-network specialist, then the network provider is required to obtain precertification from the Medical Claims Administrator before the appointment or procedure is provided. If the Medical Claims Administrator precertifies the referral*, you will be reimbursed at the network level of benefits.

*No paper referral is required.

Non-network. If you see a non-network specialist without an authorized referral from the Medical Claims Administrator, the Plan will pay 75 percent of Eligible Expenses, after the Annual Deductible is met.

Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Surgical Procedures

Network. You pay a $60 Copayment for the hospital admission. Then, any Eligible Expenses, including physician fees, are covered at 100 percent of Eligible Expenses when surgery is performed by your PCP or a network specialist.

Non-network. When surgery is performed by a non-network provider, the Plan will pay both the facility and the non-network provider at 75 percent of Eligible Expenses after you meet the Annual Deductible. Precertification is required. Otherwise the Plan will pay $250 less than would otherwise be payable. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification and to the “Non-Network Precertification” section on Page 24 for more details. Refer to the “Medical Claims Administrator” table on Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Note: Refer to Page 52 for information on multiple surgical procedures.

Well-Child Care

Coverage for well-child care includes routine physical exams, immunizations and related lab tests and X-rays.

Network. Well-child care is provided by your network physician and is from birth to 18 years of age. You will pay a $5 Copayment for each visit. The Plan will cover 100 percent of Eligible Expenses.

Non-network. Well-child care is from birth to 18 years of age. From birth to 12 years of age the Plan will cover a maximum of $150 per year of Eligible Expenses after you meet the deductible. For ages 13 to 18, the Plan will cover up to a total of four visits at a maximum of $50 per visit of Eligible Expenses after deductible.

The PPO/Non-PPO

The Preferred Provider Organization (PPO) is a network of physicians and hospitals that have agreed to accept a negotiated rate for their services. If you and/or any dependents live outside the HCN area, you will receive benefits through the PPO/Non-PPO, unless you voluntarily enroll in the HCN or enroll in an HMO or other alternative managed care product, if available in your area. When receiving health care services, you can choose to receive treatment from PPO or...
Non-PPO providers and/or facilities each time you receive care. Your benefit amount if a Non-PPO provider is used is based on the Eligible Expenses. Your benefit amount if a PPO provider is used is based on the negotiated PPO Fee. The PPO Fee is based on the fee your PPO provider accepts for similar services and the fees other providers in the same geographic area usually accept for those similar services.

The PPO/Non-PPO has a combined Annual Deductible of:
- $150 per Individual, or
- $300 for Individual plus one or Individual plus two or more

Eligible Expenses you pay, whether they are PPO or Non-PPO providers, will be counted toward your combined Annual Deductible.

**Using PPO Providers**
When you use the services of a PPO provider, the Plan will pay 100 percent of Eligible Expenses, except as noted in this SPD, up to the PPO Fee, after you meet your Annual Deductible. When you use a PPO provider, you are not responsible for any Eligible Expenses, except as noted in this SPD, above the PPO Fee. PPO providers will file your claim for you.

**Using Non-PPO Providers**
When you use the services of a Non-PPO provider, the Plan will pay 90 percent of Eligible Expenses up to the applicable R&C Fee, except as noted in this SPD, after you meet your Annual Deductible. Once you reach the Annual Out-of-Pocket Maximum (which includes your Annual Deductible) of:
- $650 per Individual, or
- $1,300 for Individual plus one or Individual plus two or more

100 percent of your Eligible Expenses will be paid for the remainder of the calendar year, up to the applicable R&C Fee.

If you or your dependent receives treatment from a Non-PPO provider, you may have to file a claim and submit it, along with an itemized bill, to the Medical Claims Administrator. Your reimbursement amount is based on the Eligible Expenses for your treatment, after the Annual Deductible for Eligible Expenses.

*Note: If you choose to receive services from Non-PPO providers, you are responsible for any deductibles, Copayment/Coinsurance, or expenses above the R&C Fee, and any other ineligible expenses. Ineligible expenses do not apply to your Annual Deductible or Annual Out-of-Pocket Maximum.*

**How the PPO/Non-PPO Works**
The Plan’s PPO enables you to receive health care benefits from a group of hospitals, physicians, and other health care providers, approved by the Medical Claims Administrator, who have agreed to accept set fees for medical services. Through this option, you can choose to receive your health care from a PPO or Non-PPO provider at the time of your treatment. By providing this flexibility, the PPO enables you to choose the physician and level of expenses you are willing to pay.
When You Are Eligible
You can participate in the PPO/Non-PPO option if you live in an area that is not a mandatory ZIP code area*. You may also voluntarily enroll in the HCN or an HMO or other alternative managed care product option, if available in your area.

*There are no mandatory ZIP codes (i.e., enrollment in the HCN is voluntary), in Illinois, Indiana, Ohio, Michigan or Wisconsin, whether or not the criteria is met as described on Page 20. This excludes employees covered by the collective bargaining agreement with IBEW 494.

Receiving PPO/Non-PPO Benefits
Your benefit level under the PPO/Non-PPO is based on whether you receive treatment from a PPO or Non-PPO physician, provider or hospital. Each time you need medical care, you can choose to use a PPO or Non-PPO physician, provider or hospital.

DID YOU KNOW ... It is your responsibility to select a PPO provider before you receive medical treatment? If you inadvertently use a Non-PPO provider, you will be responsible for any ineligible expenses under the Non-PPO provisions of the PPO/Non-PPO. So, be sure to verify ahead of time that the provider is a PPO provider by contacting the Medical Claims Administrator and asking the provider’s office before receiving medical treatment.

You may need to file a claim to receive reimbursement if Non-PPO services are used. All services must be Medically Necessary in order to be considered an Eligible Expense payable under the Plan. Refer to the “Definitions” section on Page 82 and the “Common Services or Supplies Covered by the Plan” section on Page 44 for further information.

The table below also lists the PPO/Non-PPO Annual Deductible, Annual Maximum Copayment/Coinsurance and Annual Out-of-Pocket Maximum by Level of Coverage.

<table>
<thead>
<tr>
<th>PPO/Non-PPO BENEFITS</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>1, 3, 4</td>
<td>The PPO/Non-PPO has a combined Annual Deductible of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $150 per Individual, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $300 for Individual plus one or Individual plus two or more</td>
</tr>
<tr>
<td><strong>Eligible Expenses Covered by the Plan</strong></td>
<td>100% of PPO Fee</td>
<td>90% of Eligible Expenses for facilities, after deductible, if applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90% of Eligible Expenses for other providers, after deductible, if applicable</td>
</tr>
</tbody>
</table>
## PPO/Non-PPO Benefits

Your PPO/Non-PPO benefits depend on the type of provider you see for medical treatment. You may need to file a claim to receive reimbursement if Non-PPO services are used. All services must be Medically Necessary in order to be considered an Eligible Expense payable under the Plan. Refer to the “Definitions” section on Page 82 and the “Common Services or Supplies Covered by the Plan” section on Page 44 for further information.

<table>
<thead>
<tr>
<th>PPO/Non-PPO Plan Feature</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization/ Ambulatory Surgical Center&lt;br&gt;Precertification required</td>
<td>100% of Eligible Expenses, after deductible</td>
<td>90% of Eligible Expenses, after deductible</td>
</tr>
<tr>
<td>Physician Office Visits&lt;br&gt;Precertification not required</td>
<td>100% of Eligible Expenses up to the PPO Fee, after deductible</td>
<td>90% of Eligible Expenses, after deductible</td>
</tr>
<tr>
<td>In-Hospital Physician/Specialist Visit</td>
<td>1 visit per day for each specialty; the Medical Claims Administrator will determine if more than 1 visit per day is Medically Necessary</td>
<td></td>
</tr>
<tr>
<td>PPO/Non-PPO Plan Feature</td>
<td>PPO</td>
<td>Non-PPO</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Outpatient Procedures</strong>&lt;br&gt;(for services listed in Appendix A)&lt;br&gt;Precertification required</td>
<td>Procedure Expenses: 100% of Eligible Expenses, with no deductible&lt;br&gt;Facility Expenses: 100% of Eligible Expenses, with no deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Procedures</strong>&lt;br&gt;(for services other than those listed in Appendix A)</td>
<td>See Hospitalization/Ambulatory Surgical Center</td>
<td>See Hospitalization/Ambulatory Surgical Center</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong>&lt;br&gt;Precertification not required</td>
<td>100% of Eligible Expenses, after deductible</td>
<td>90% of Eligible Expenses, after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room Treatment</strong>&lt;br&gt;Precertification not required</td>
<td>100% of Eligible Expenses, after deductible</td>
<td>90% of Eligible Expenses, after deductible</td>
</tr>
<tr>
<td><strong>Wellness Care</strong>&lt;br&gt;<em>Disease Detection Tests</em>&lt;br&gt;Precertification not required</td>
<td>Up to $125 of Eligible facility Expenses or PPO Fee, including related physician fees, with no deductible or Copayment/Coinsurance, subject to the frequency limits on Page 40</td>
<td>Up to $125 of Eligible facility Expenses, including related physician fees, with no deductible or Copayment/Coinsurance, subject to the frequency limits on Page 40</td>
</tr>
<tr>
<td><strong>Disease Detection Tests</strong>&lt;br&gt;<em>Pap Test and Mammogram</em>&lt;br&gt;Precertification not required</td>
<td>Tests are covered at 100% of billed charges and are not subject to the deductible or applied to the Disease Detection benefit limit but are subject to frequency limits on Page 40.</td>
<td></td>
</tr>
<tr>
<td><strong>Well-Child Care</strong>&lt;br&gt;<em>Birth to Age 12</em>&lt;br&gt;Precertification not required</td>
<td>100% of Eligible Expenses up to $175 per year per child; no deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Age 13 to 18</strong>&lt;br&gt;Precertification not required</td>
<td>Total of 4 visits covered at 100% of Eligible Expenses with a maximum of $50 per visit; no deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Second Opinions</strong>&lt;br&gt;Precertification required</td>
<td>100% of Eligible Expenses up to the PPO Fee, after deductible</td>
<td>100% of Eligible Expenses after deductible; 90% of Eligible Expenses, after deductible if not precertified</td>
</tr>
</tbody>
</table>
Organ Transplant

*Note: For all Type A and Type B Procedures, benefits will be paid only if precertification was received and performed at an Approved Transplant Facility.*

<table>
<thead>
<tr>
<th>PPO/Non-PPO Plan Feature</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cornea, kidney, heart valve, tissue, and bone marrow transplants</td>
<td>100% of Eligible Expenses, after deductible</td>
<td>90% of Eligible Expenses, after deductible</td>
</tr>
<tr>
<td><strong>Type B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart, liver, heart-lung, pancreas-kidney, pancreas, and isolated or bilateral organ transplants</td>
<td>100% of Eligible Expenses, after deductible</td>
<td>90% of Eligible Expenses, after deductible</td>
</tr>
</tbody>
</table>

Diagnostic X-Rays And Laboratory Tests

*Precertification not required*

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Eligible Expenses, if performed in outpatient setting, after deductible</td>
<td>90% of Eligible Expenses, if performed in outpatient setting, after deductible</td>
</tr>
</tbody>
</table>

Pre-Admission Testing

*Precertification required*

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Eligible Expenses, if performed in outpatient setting, after deductible</td>
<td>90% of Eligible Expenses, if performed in outpatient setting, after deductible</td>
</tr>
</tbody>
</table>

Chiropractic Coverage

*Note: A maximum of $200 per year per individual applies.*

*Precertification not required*

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Eligible Expenses up to the PPO Fee, after deductible</td>
<td>90% of Eligible Expenses, after deductible</td>
</tr>
</tbody>
</table>

Hearing Test and Hearing Aid Appliance

*Refer to Page 41 for specifics on how to use this benefit.*

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test:</td>
<td>100% of Eligible Expenses up to the PPO Fee after deductible</td>
<td>90% of Eligible Expenses after deductible</td>
</tr>
<tr>
<td>Appliance:</td>
<td>Based on a rolling 36-month period, up to a $1,000 maximum</td>
<td>Based on a rolling 36-month period, up to a $1,000 maximum</td>
</tr>
</tbody>
</table>

*Note: For all Approved Home Care, Hospice Care and Skilled Nursing Facilities, benefits will be paid only if precertification was received. Otherwise no benefits will be paid.*

Approved Home Care Agency

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Eligible Expenses, no deductible</td>
</tr>
</tbody>
</table>

Hospice

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Eligible Expenses, no deductible, physician’s diagnosis of terminal illness</td>
</tr>
</tbody>
</table>

Skilled Nursing Facility

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Eligible Expenses, no deductible, if transferred directly to facility from hospital and if physician prescribed</td>
</tr>
</tbody>
</table>

*Note: After you meet the Annual Out-of-Pocket Maximum, benefits will be paid at 100 percent of Eligible Expenses or PPO Fee. Refer to the “Definitions” section on Page 82 to find out how the Annual Out-of-Pocket Maximum is met.*
PPO/Non-PPO Precertification
If you do not obtain precertification when required before receiving services, having a procedure done or obtaining supplies, the PPO/Non-PPO will pay $250 less than would otherwise be payable. In addition, in the case of an Approved Home Care Agency, Hospice Care, Skilled Nursing and Transplant Procedures, the Plan will not pay any benefits. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information. Precertification is not a determination of eligibility for benefits or participation in the Plan.

Further Details on Your PPO/Non-PPO Benefits

Adult Physical Exams and Routine Gynecological Exams
Adult physical exams and routine gynecological exams are not covered under the PPO/Non-PPO.

Approved Home Care Agency and Hospice Care
If your Approved Home Care Agency care or Hospice Care is precertified, the Plan will pay 100 percent of Eligible Expenses with no deductible.

Note: If you or your covered dependents receive Approved Home Care Agency care or Hospice Care without precertification, the Plan will not pay any benefits.

Disease Detection Tests
The Plan provides a $125 cumulative annual benefit, before you meet your Annual Deductible, for certain tests and related physician services that are performed to detect disease in the early stages. You are responsible for any expenses over the $125 cumulative annual benefit, subject to the frequency limit noted below.

Disease detection tests include:

- Fecal occult blood tests (once annually)
- Total serum cholesterol tests (once annually)
- Blood glucose tests for diabetes (once annually)
- Sigmoidoscopies (once every three years for ages 50-59 and every year for ages 60 and over)

The following tests are covered at 100 percent of billed charges and are not subject to the Annual Deductible or applied to the disease detection benefit limit, subject to the frequency limit noted below.

- Pap test
- Mammograms (every other year for ages 40-49 and every year for ages 50 and over)
Hearing Test

**PPO.** The Plan will pay 100 percent of Eligible Expenses up to the PPO Fee after the deductible for the office visit and hearing test.

**Non-PPO.** The Plan will pay 90 percent of Eligible Expenses after the deductible for the office visit and hearing test.

If your PPO or non-PPO physician refers you to an audiologist for a hearing test, the reimbursement for the test will be made at the PPO level of benefits if it was a PPO provider that referred you to an audiologist. If it was a non-PPO provider that referred you to an audiologist, the test will be reimbursed at the non-PPO level of benefits.

If your physician’s office does not submit a bill/claim for the hearing test, you must submit, along with your bill/claim, either a prescription or a signed letter from your physician on his or her letterhead that refers you to an audiologist for testing and/or establishes Medical Necessity for you to purchase a hearing aid appliance.

**Important:** The same prescription or letter signed by the physician on the physician’s letterhead can be used when submitting the claim for the hearing test/exam as well as for the hearing aid appliance. If you submit a claim without the appropriate documentation, the claim will not be paid.

Note: The office visit and/or test to determine hearing loss is covered under the Plan and is not subject to the $1,000 cap for the hearing aid appliance.

Hearing Aid Appliance

**If You Purchase a Hearing Aid Appliance Through Your Physician.** If your physician’s office submits the bill/claim for a hearing aid appliance purchase, the hearing aid appliance reimbursement will be payable up to $1,000 of billed charges, in each rolling 36-month period, which begins on the date of purchase.

**If You Purchase a Hearing Aid Appliance From a Source Other Than Your Physician.** If your physician’s office does not submit a bill/claim for your hearing aid appliance purchase, you must submit, along with your bill/claim, either a prescription or a signed letter from your physician on his or her letterhead that refers you to an audiologist for testing and/or establishes Medical Necessity for you to purchase a hearing aid appliance. The hearing aid appliance reimbursement will be payable up to $1,000 of billed charges, in rolling each rolling 36-month period, which begins on the date of purchase.

**Important:** The same prescription or letter signed by the physician on the physician’s letterhead can be used when submitting the claim for the hearing test/exam as well as for the hearing aid appliance. If you submit a claim without the appropriate documentation, the claim will not be paid.

These procedures have been designed because there currently are no network audiologists or hearing aid appliance providers in the Plan and the R&C Fee is not calculated for the hearing aid appliance. If either becomes available, these procedures will be revised, if appropriate.

Note: The Plan will cover the first hearing aid following illness or injury, and it is NOT subject to the $1,000 cap.
Organ Transplants

**Important:** All Type A and Type B procedures must be precertified and be performed at an Approved Transplant Facility. Otherwise, no benefits will be paid.

The following information refers specifically to the PPO/Non-PPO provisions of the CHCP. More information on organ transplants is included in the “Common Services or Supplies Covered by the Plan” section on Page 44.

**Type A Procedure Coverage**

Type A procedures include cornea, kidney, heart valve, tissue, and bone marrow transplants and are covered by the Plan at the following levels after you receive precertification and if you use an Approved Transplant Facility.

- **PPO.** Procedures are covered at 100 percent of Eligible Expenses after you meet your deductible.

- **Non-PPO.** When you use a Non-PPO facility, the Plan will cover 90 percent of Eligible Expenses after you meet your deductible.

**Type B Procedure Coverage**

Type B procedures include human heart, liver, heart-lung, pancreas-kidney, pancreas, and isolated or bilateral organ transplants and are covered by the Plan at the following levels after you receive precertification and use an Approved Transplant Facility.

- **PPO.** For procedures performed at an Approved Transplant Facility, the Plan will cover 100 percent of your Eligible Expenses after you meet your deductible.

- **Non-PPO.** For procedures performed at an Approved Transplant Facility, the Plan will cover 90 percent of your Eligible Expenses after you meet your deductible.

Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification and to the “PPO/Non-PPO Precertification” section on Page 40 for more details. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

**Outpatient Procedures**

The Plan will reimburse 100 percent of Eligible Expenses for certain procedures (refer to the list of procedures provided in Appendix A on Page 79) and 100 percent of Eligible Expenses for the outpatient facility, with precertification. A deductible does not apply. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification and to the “PPO/Non-PPO Precertification” section on Page 40 for more details. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

**Second Opinions**

When your physician recommends extensive laboratory tests, surgical procedures, or another treatment option, a second opinion confirming your physician’s recommendation may be a good idea. There are different ways to treat certain medical conditions and second opinions can help avoid the cost and discomfort of unnecessary procedures. If precertified, the Plan will pay
100 percent of the PPO Fee or Eligible Expenses after the deductible for the cost of a second opinion. If not precertified, and a Non-PPO provider is used, the Plan will pay 90 percent of Eligible Expenses, after the deductible for the cost of a second opinion.

Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification and to the “PPO/Non-PPO Precertification” section on Page 40 for more details. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

**Skilled Nursing Facility**

Skilled Nursing Facility Eligible Expenses are covered at 100 percent, with no deductible, if prescribed by your physician and precertified.

*Note: If you or your covered dependent receives care in a Skilled Nursing Facility without precertification, the Plan will not pay any benefits.*

Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification and to the “PPO/Non-PPO Precertification” section on Page 40 for more details. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

**Surgical Procedures**

Surgical procedures that are Medically Necessary and considered to be Eligible Expenses are covered up to 100 percent of the PPO Fee after your deductible is met, if you use a PPO provider. Non-PPO surgical procedures that are Medically Necessary are covered at 90 percent of Eligible Expenses after your deductible.

**Important:** All non-emergency surgical procedures must be precertified in advance whether using PPO or Non-PPO providers.

*Note: Refer to Page 52 for information on multiple surgical procedures.*

**Third Opinions**

If you obtain a second opinion that does not agree with your physician’s recommendation, you may request a third opinion. If precertified, the Plan will cover the third opinion and any diagnostic tests at 100 percent of Eligible Expenses or PPO Fee, after you meet the Annual Deductible. If not precertified, and a Non-PPO provider is used, the Plan will pay 90 percent of Eligible Expenses after the deductible for the cost of a third opinion. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification and to the “PPO/Non-PPO Precertification” section on Page 40 for more details. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

**Well-Child Care**

Well-child care includes routine office visits for checkups, related lab tests and X-rays, and immunizations otherwise unrelated to an illness. A deductible does not apply. Refer to the “PPO/Non-PPO Plan Features” table on Page 37 for more details.
Common Services or Supplies Covered by the Plan

Whether you are enrolled in the HCN or PPO/Non-PPO option, there are a number of common services or supplies that both options cover. However, benefits will only be paid for a covered service or supply if your treatment is determined to be Medically Necessary by the Medical Claims Administrator. If your treatment is covered by the Plan and considered Medically Necessary, the Plan will cover any Eligible Expenses incurred for that treatment, subject to any applicable deductibles and Copayments/Coinsurance requirements. Refer to the “Eligible Expenses” section on Page 45 for detailed information about Eligible Expenses.

Refer to “The Health Care Network (HCN)” section on Page 20 and “The PPO/Non-PPO” section on Page 34 for information concerning levels of coverage.

Ambulance Service

In the event of an accidental injury or sudden illness, the HCN or PPO/Non-PPO covers professional ground ambulance service to the nearest hospital. If proper treatment cannot be provided at the nearest hospital, the HCN or PPO/Non-PPO covers ambulance service to the nearest approved facility. Under certain circumstances, such as injury or illness in a remote area that cannot be reached by ground ambulance, air ambulance or air transportation to a hospital is covered without precertification.

Important: If the circumstances are not life threatening, air ambulance or air transport requires precertification. Otherwise the Plan will pay $250 less than would otherwise be payable or may not pay any benefits. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Approved Home Care Agency, Hospice Care and Skilled Nursing Facilities

If you or a covered dependent require professional medical help at home or Hospice Care, the Plan may provide coverage under certain circumstances. If you are in the HCN and using non-network services, or if you are in the PPO/Non-PPO option, you must receive precertification of the care. Otherwise the Plan will not pay any benefits. In some circumstances, your physician must propose a treatment plan to the Medical Claims Administrator to obtain precertification and indicate that you would require hospitalization or admission into a nursing home or Skilled Nursing Facility if an Approved Home Care Agency was not available. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Approved Home Care Agency. An Approved Home Care Agency is designed to assist you when you need professional help at home for a specified period of time. It includes skilled nursing care, therapist and Approved Home Care Agency aide home visits, nutritional therapy, and covered medical supplies prescribed by a physician.

Hospice Care. Care designed for terminally ill patients with a life expectancy of six months or less is considered Hospice Care. It includes physician, nurse, social worker, clergy, psychologist, psychiatrist and other professional services, as well as counseling for family members after the patient dies. The hospice must meet specific Plan requirements including
state licensing and/or Medicare hospice certification and the provision of 24-hour per day care to control the symptoms of the terminal illness.

**Skilled Nursing Facility.** Skilled Nursing Facilities provide full-time nursing care and related health care services for a specified period of time if you require continuous medical treatment after you are discharged from the hospital.

Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

**Chiropractic Care**
Chiropractic services must be performed by a licensed chiropractor or osteopath and include chiropractic adjustments and manipulations to be considered Eligible Expenses.

**Eligible Expenses**
Eligible Expenses are expenses or charges (or portion thereof) incurred for Medically Necessary covered services, treatments or supplies recommended by the Physician that are determined by the Medical Claims Administrator to be within the amount provided under an applicable contractual arrangement with the respective provider of the service, treatment or supply, or the applicable R&C Fee. Covered services include, but are not limited to:

- Administration of anesthesia, either in or out of the hospital, by a physician or qualified anesthesiologist other than the physician performing the surgery or his/her assistant
- Breast reconstructive surgeries as follows:
  - Reconstruction of the breast on which a mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas
- Implantations of temporary prosthetic devices that are external and removable, and permanent internal devices such as heart pacemakers
- Radiation and electroshock therapy (in or out of the hospital)
- Chemotherapy (in or out of the hospital)
- Cardiac rehabilitation (up to a maximum of 36 sessions per illness)
- Initial purchase of prosthetic limbs, eyes, and other devices which replace parts of the body and attach to the body (excluding natural teeth and gums, unless there is an accidental injury to natural teeth)
- Rental of durable medical or surgical equipment (or purchase, if required for a prolonged period of time)
- Purchase of required minor equipment and supplies (including, but not limited to, nebulizers, canes, trusses, crutches, surgical belts and supports, and special corsets)
- Physical, speech, and occupational therapy
- Initial male or female sterilization procedures and their reversal
Sex change operations with evidence of Medical Necessity

Emergency Care
Whether you are covered by HCN or PPO/Non-PPO benefits, in an emergency you should obtain the necessary medical treatment at the nearest emergency facility. Emergency care is appropriate when, in the absence of immediate medical attention, the situation could result in serious and permanent medical consequences. All true emergencies, including accidental injuries, such as broken bones and sudden, serious illnesses, are covered no matter where you receive treatment. Emergency treatment should be rendered within 48 hours from the initial onset of the accident, injury, or illness to be considered an emergency.

Examples of an Emergency. An emergency occurs when medical care is needed due to a sudden and unexpected onset of a medical condition accompanied by severe symptoms that occur unexpectedly and require immediate medical attention. Examples of such an emergency include, but are not limited to:

- Acute appendicitis
- Asthmatic attack
- Hemorrhage
- Food poisoning
- Drug overdose
- Frostbite
- Convulsions
- Loss of consciousness
- Fractures
- A foreign body in the eye, ear, nose, or throat
- Coma

Note: The Medical Claims Administrator will determine if the care provided was for an emergency situation based on documentation from the emergency facility and/or the attending physician.

Hospital Expenses
As with all expenses, procedures performed in a hospital must be considered Medically Necessary and be considered an Eligible Expense to be covered by the HCN or PPO/Non-PPO. In addition, to receive benefits, you must receive precertification in certain circumstances. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Covered hospital expenses include, but are not limited to:

- Ward or semi-private rooms
- Rooms for special care including intensive care, cardiac care, and isolation rooms
- Private rooms, up to the semi-private room rate
- Special diets
- General nursing care
- Routine nursery care of a newborn infant during the mother’s covered hospitalization
- Use of operating, delivery, recovery, and treatment rooms and equipment
- All FDA-approved drugs and medicines for use in the hospital
- Dressings, splints, casts, and necessary central supply items
- X-ray examinations, X-ray therapy, and radiation therapy and treatment
- Laboratory tests that are not duplications of tests done before admission and paid by the Plan unless the Medical Claims Administrator determines that duplicate tests are Medically Necessary
- CAT scans and nuclear medicine
- Oxygen and oxygen therapy, including the use of equipment for its administration
- Electrocardiograms and electroencephalograms
- Physical and occupational therapy
- Anesthetics and their administration
- Processing and administering blood and blood plasma
- Use of heart-lung and kidney machines

**Dental Hospitalization.** Hospital expenses are covered if you are hospitalized for dental care because you experience:

- An accidental bodily injury
- A physician, other than your dentist, certifies that hospitalization is necessary to ensure proper medical care because of a specific non-dental impairment

**In-Hospital Physician or Specialist Visits.** Under the Plan, in-hospital physician or specialist visits are covered for each medical specialty. The Plan will **not** cover physician or specialist visits for:

- Pre- or post-operative treatments
- Dental treatments
- Eye exams or eyeglass fittings

**Pre-Admission Hospital Testing.** Generally, pre-admission tests are required before you are admitted into a hospital and are performed in an outpatient setting, such as a hospital outpatient department or Ambulatory Surgical Center. These services are covered by the Plan if:

- A resulting hospitalization is Medically Necessary and a bed reservation has been made before the testing is performed
- The tests are Medically Necessary and consistent with the diagnosis and treatment of the condition
- The admission is not canceled or postponed (unless this happens as a result of a second opinion, test results, or other medical reasons)
- The tests are not later repeated in the hospital after you are admitted (unless repetition of the tests is Medically Necessary)

**Weekend Hospital Admissions.** Room and board and services provided by licensed hospitals, physicians, and registered nurses are covered under the Plan if:

- You or a covered dependent are admitted to the hospital on Friday or Saturday due to an emergency
- Treatment or surgery is performed the next day

If these conditions are not met, non-emergency treatments will still be covered, but any Saturday or Sunday room and board expenses will not be covered by the Plan. Additionally, the Plan will not cover services received at health resorts, rest homes, or nursing homes.

**Maternity Benefits**
You and your covered dependents are eligible for maternity benefits, including:

- Services performed on or after the date the mother becomes covered under this Plan, even if the pregnancy began before the mother was covered
- Pre-natal and post-natal care
- Delivery charges, cesarean section, ectopic pregnancy, miscarriage, or abortion (voluntary or therapeutic)
- Circumcision of a baby, if performed by a physician or surgeon
- Nurse-midwives, if the midwife is permitted to practice independently of a physician by local state regulations

*If your hospital admission is longer than the time periods stated below, you must contact the Medical Claims Administrator and obtain authorization for the extension.* If you are in the HCN and using network services, hospital stays longer than 48 hours for vaginal deliveries and 96 hours for delivery by cesarean section, your network physician will contact the Medical Claims Administrator and coordinate the extension. Otherwise, the Plan will pay reduced benefits.

Group health plans and health insurance issuers may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, Federal law does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, if applicable).
Important: Any hospital maternity stay longer than 48 or 96 hours, as applicable, must be approved by the Medical Claims Administrator. If you are using a network physician, the physician will contact the Medical Claims Administrator and coordinate the extension, as indicated.

Maternity benefits in the hospital include one pediatric examination of the newborn and nursery charges during the mother’s hospital stay. If the newborn needs specific treatment or examinations for medical reasons, the HCN or PPO/Non-PPO covers the newborn as an individual dependent.

Refer to the “Eligible Dependents” section on Page 58.

Important: Your newborn is eligible for coverage at birth, but you must enroll the newborn with the Enrollment and Eligibility Vendor within 31 days from his or her date of birth in order to receive Plan benefits from the date of birth. Refer to the “Enrollment and Eligibility Vendor” table on Page 114 for contact information. If your dependent child has a child, the newborn’s first in-hospital pediatric exam is covered as part of the mother’s coverage. No other coverage for the newborn is available and no other expenses will be paid for the newborn.

Prospective Enrollment for a Newborn. If you do not add your newborn within the 31-day period described above, prospective enrollment allows you to add him or her prospectively. When you do this, the effective date of the newborn’s coverage will be the first of the month following the date you request the change. Refer to the SBC Flexible Spending Account Plan SPD for information on whether prospective enrollment will affect the amount of your pre-tax deduction, if any.

Medically Necessary
A specific medical, health care or hospital service or supply is Medically Necessary if, in the reasonable medical judgment of the appropriate Claims Administrator, the service or supply is required for the treatment or management of a medical symptom or condition and the service or care provided is the most efficient and economical care or service which can be safely provided. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not itself make that service or supply Medically Necessary.

For MH/SA treatment to be considered Medically Necessary, the following provisions also apply. The MH/SA treatment must:

- Be adequate and essential for evaluation and/or treatment of a condition or illness, as defined by standard diagnostic criteria
- Reasonably expected to improve an individual’s condition or level of functioning
- Meet national standards which are defined by clinical references, valid empirical experience for efficacy, and/or national professional standards
- Be provided in the most independent, appropriate setting

Important: Remember, precertification is necessary for MH/SA benefits to be covered. Eligible MH/SA Expenses that are not precertified will not be paid under the Plan, even if you use a network provider.
**Not Medically Necessary.** Charges will not be considered Medically Necessary when diagnosis, care, or treatment is of unproven or questionable value; unnecessary when performed in combination with other care; custodial in nature; unlikely to provide a Physician with additional information when used repeatedly; or not ordered by a Physician. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not itself make that service or supply Medically Necessary.

If treatment or observation of a condition can safely be done at an outpatient facility, the Plan will not pay any benefits if you are admitted into a hospital. Examples of hospitalization and other health care services that are not Medically Necessary include, but are not limited to:

- Hospital admissions to observe or evaluate a medical condition that could have been provided safely and adequately in another setting such as a hospital’s outpatient department
- Hospital admissions primarily for diagnostic studies (X-rays, laboratory and pathological services, and machine diagnostic tests) which could be safely done in another setting on an outpatient basis
- Continued inpatient hospital care when the patient’s medical symptoms and condition no longer require continued stay
- Hospitalization or admission to a Skilled Nursing Facility, nursing home, or other facility for the primary purpose of Custodial Care, convalescent care, rest cures, or domiciliary care to the patient
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or physician or because care in the home is not available or is unsuitable
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care, or to provide services for the convenience of the patient and/or his or her family

The appropriate Claims Administrator will decide whether hospitalization or other health care services or supplies are Medically Necessary, and, therefore, eligible for payment. If you have any questions about whether a service or supply is considered Medically Necessary, contact the appropriate Claims Administrator.

**Organ Transplants**

**Important:** Type B procedures performed by a non-network provider or at a non-network facility are not covered by the Plan. Also, all Type A and Type B Procedures must be precertified to receive coverage and be performed at an Approved Transplant Facility.

**Type A Procedures.** Type A procedures include cornea, kidney, heart valve, tissue, and bone marrow transplants and must be precertified by the Medical Claims Administrator. In addition, procedures must be performed at an Approved Transplant Facility.

Coverage for Type A procedures is determined as follows:

- If the recipient and donor are both covered by the Plan, both patients will receive benefits.
- If only the recipient is covered by the Plan, the donor and recipient will receive benefits from the Plan to the extent that benefits to the donor are not provided by another plan.
If the donor is covered by the Plan and the recipient’s plan does not provide for the donor’s expenses, the Plan will cover the donor’s expenses only. The recipient will not receive any Plan benefits.

**Type B Procedures.** Type B procedures include human heart, liver, heart-lung, pancreas-kidney, pancreas, and isolated or bilateral organ transplants and must be precertified by the Medical Claims Administrator. In addition, procedures must be performed at an Approved Transplant Facility.

Covered Type B procedures include:

- The evaluation of the donor organ
- The removal of the organ from the donor
- Transportation of the organ to the operation location (if in the United States or Canada)
- Patient expenses up to a maximum of $5,000 for transportation and $5,000 for lodging (this reimbursement amount is separate from your Plan deductible and Copayments/Coinsurance and can include expenses for more than one person, provided you do not exceed the maximums). Those eligible to accompany the patient are not limited to family members.

To be eligible for coverage for a Type B procedure, the following criteria must be met:

- You must face a high risk of death if the procedure is not done.
- You must not have another diagnosed terminal illness.
- Certain other requirements must be met as determined by the Medical Claims Administrator, such as sufficiently high survival rates for patients undergoing the procedure at that hospital, or for the transplant team requesting to perform surgery.

The Plan will not cover any ineligible expenses relating to Type B procedures, including:

- Services unrelated to the transplant or to the diagnosis or treatment of an illness resulting directly from the transplant
- Cardiac rehabilitation services, unless you receive treatment immediately after you are discharged from the hospital
- Your physician’s travel time and any other related expenses
- Experimental drugs which have not been approved by the Food and Drug Administration

**Outpatient Procedures**

Many times, treatment can be performed at an outpatient facility such as:

- Hospital outpatient departments
- Physicians’ offices
- Ambulatory surgical centers
When you receive outpatient care, your expenses generally will be less than if you were admitted to a hospital for similar treatment. In addition, outpatient care enables you to recover in the comfort of your home. Refer to Appendix A on Page 79 for a list of outpatient procedures.

**Surgical Procedures**

Covered surgical procedures include, but are not limited to:

- Operative or cutting procedures
- Treatment of fractures or dislocations
- Suturing of lacerations
- Endoscopic and similar procedures
- Customary pre- and post-operative care (except in-hospital physicians' visits)
- Dental surgery if it results from accidental injury to your natural teeth
- Reconstructive surgery if it results from accidental injury or disease or is needed to correct a congenital deformity or abnormality and is determined by the Medical Claims Administrator to be Medically Necessary

**Multiple Surgical Procedures**

When a surgeon performs several procedures during the same operating session, these services are called multiple surgical procedures. Eligible Expenses are paid as follows:

- Multiple surgical procedures performed during the same operative session through the same incision or in the same operative field are covered up to the R&C or PPO Fee for the most expensive procedure.
- Multiple surgical procedures performed during the same operative session through separate incisions and in separate operative fields shall be payable up to the R&C or PPO Fee for the total procedure but not to exceed the R&C or PPO Fee for the greater procedure plus 50 percent of the R&C or PPO Fee for the lesser procedure(s).
- Bilateral procedures performed during the same operative session in separate operative fields are payable up to the R&C or PPO Fee for the total procedure which should not exceed 150 percent of the R&C or PPO Fee for the unilateral procedure.
- Multiple surgical procedures involving more than one physician having different specialties are treated independently; however, only one Eligible Expense is allowed for the operating room and only one Eligible Expense is allowed for the anesthesia.

Contact the Medical Claims Administrator if you are using a combination of network and non-network or PPO and Non-PPO providers or facilities. The level of reimbursement may be affected for multiple surgical procedures.
Important: All non-emergency surgical procedures must be precertified at least 10 days in advance if using non-network, PPO or Non-PPO providers. If you do not obtain precertification when required before having a procedure done or obtaining supplies, the Plan will pay $250 less than would otherwise be payable. In addition, in the case of an Approved Home Care Agency, Hospice Care, Skilled Nursing and Transplant Procedures, the Plan will not pay any benefits. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Temporomandibular Joint (TMJ)
The Plan covers surgical services submitted with a TMJ diagnosis as any other surgical procedure would be covered under the Plan. Non-surgical services such as exams, consultations, study models and photos, X-rays, repositioning appliances/TMJ splints, physical therapy with respect to a TMJ diagnosis are covered. To receive benefits, you must receive precertification before receiving surgical treatments.

Non-surgical dental treatment of TMJ and Bruxism, including orthodontic bite adjustments, night guards, crowns, bridges, onlays, or tooth replacement are excluded from the Plan. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Medical Claims Administrator” table on Page 104 or Page 108 for contact information and to Appendix D on Page 122 for additional precertification information.

Urgent Care Access
Illness and injuries that are of a less serious nature than an emergency may require urgent care. Urgent care centers are usually open evenings, weekends and holidays and are designed to give patients fast, effective service and to prevent a serious decline in health. Urgent care centers commonly treat conditions such as:

- Minor injuries and cuts
- Upper respiratory infections
- Ear infections
- Sprains
- Sore throats
- Urinary tract infections

Note: The Medical Claims Administrator will determine if the care provided was for urgent care or an emergency based on documentation from the urgent care facility and/or the attending physician. For examples of emergencies, refer to the “Emergency Care” section on Page 46.

Common Services and Supplies That Are Not Covered by the Plan
In addition to the exclusions and limitations specified elsewhere in this SPD, expenses not covered by the Plan include, but are not limited to:

- Services or supplies that are not Medically Necessary
- Expenses in excess of the R&C or PPO Fee
- Expenses resulting from an on-the-job illness or injury covered by Workers' Compensation
- Pre-marital examinations
- Routine physical examinations, except as specifically provided under the HCN for network benefit levels
- Expenses covered under the Ameritech Dental Expense Plan or Ameritech Vision Care Plan
- Expenses incurred before an individual becomes eligible for Plan participation
- Charges for Experimental or Investigational Procedures, treatment methods, drugs, or devices determined by the appropriate Claims Administrator
- Charges for more than two substance abuse treatments while covered by the Plan
- Charges in excess of $75,000 (for non-network treatment) during a covered person’s lifetime for mental health care
- Charges for inpatient care of substance abuse if outpatient care would have been appropriate
- Charges for convalescent, custodial, or sanitarium care or rest cures
- Charges for services received at health resorts, rest homes, or nursing homes
- Hospitalization that is primarily for observation or for diagnostic studies
- Hospital emergency room facility charges for care that is not an emergency
- Anesthesia given for a procedure not covered by the Plan
- Approved Home Care Agency, Hospice Care, psychiatric or psychological care and counseling, substance abuse care, or organ transplant procedures not precertified by the appropriate Claims Administrators
- Maintenance speech therapy and speech therapy when rendered for the treatment of psychosocial speech delay, behavioral problems, attention disorder, conceptual handicap or other learning disabilities, or mental retardation
- Charges for educational testing or training
- Routine assistance in daily living or supportive care for the patient’s or other family member’s convenience
- Charges for broken appointments, travel time, or to complete paperwork
- Personal hygiene, comfort, and convenience items commonly used for other than medical purposes, such as air conditioners, televisions, telephones, humidifiers, or physical fitness equipment
- Treatment of flat feet, routine foot care, and corrective shoes
- Eyeglasses and vision examinations
- Services and supplies provided by the federal or any state government or any agency or subdivisions thereof
- Services and supplies for which a covered person is not required to make a payment (such as for professional courtesy) or for which a covered person would have no legal obligation to pay in the absence of this or any similar coverage
- Services and supplies for any illness contracted or injury sustained as a result of war, declared or undeclared, or any act of war
- Customary pre- and post-operative treatments
- Cosmetic procedures (unless due to accidental injury, birth deformity, or breast reconstruction surgery)
- Charges for assisted reproductive procedures, including but not limited to invitro fertilization, artificial insemination, GIFT or ZIFT (intrfallopian transfer) procedures
- Procurement or use of special braces, splints, appliances, ambulatory apparatus, specialized equipment, battery or atomically controlled implants, except as specifically provided in the Plan
- Blood derivatives which are not classified as drugs in the official formularies
- Occupational and physical therapy when the purpose is to maintain, other than improve, the level of functioning
- Charges for Christian Science services
- Charges submitted after the 24-month claim submission time limit
- Treatment of temporomandibular joint syndrome (TMJ) with intra-oral prosthetic devices or any other method which alters the vertical dimension, or treatment of TMJ not caused by documented organic joint disease or physical trauma
- Wigs and wig styling
- Vitamins, food and food supplements used as dietary supplements
- Charges for hospital admission, facility or professional care incurred as part of a controlled Investigational trial, unless otherwise payable by the Plan
- Batteries

**Important**: Omission of a service or supply from this list does not automatically qualify it as an Eligible Expense under the Plan.

If you have a question about a specific procedure, service, or supply, refer to the “Contact Information” section on Page 104 to contact the appropriate Claims Administrator.

**Prescription Drug Coverage**

Your prescription drug coverage for the HCN and PPO/Non-PPO depends on the length of your prescription (i.e., short-term or long-term).

**Short-Term Prescriptions**

Short-term prescriptions are prescriptions for up to a 30-day maximum with one refill up to 30 days. After you pay an Annual $25 Deductible per Individual or an Annual $50 Deductible for Individual plus one or Individual plus two or more, short-term prescriptions are covered under the Plan at 90 percent of Eligible Expenses. After the Annual Out-of-Pocket Maximum of $100 per Individual, $200 for Individual plus one or Individual plus two or more (including deductible) is reached, short-term prescriptions are covered under the Plan at 100 percent of Eligible Expenses.
Long-Term Prescriptions
Long-term prescriptions (prescriptions for 31 days up to a maximum of 90 days) are distributed through the Mail Service Prescription Drug Program, which is administered by the Prescription Drug Claims Administrator. There is no Annual Deductible or Copayments/Coinsurance, with the exception of employees covered by the collective bargaining agreement with IBEW 494, who have a Copayment of $5 for each generic and $15 for each brand name medication.

Refer to the “How Prescription Drug Coverage Works” section on Page 74 for more details and refer to the “Prescription Drug Claims Administrator” table on Page 115 for contact information.

Mental Health/Substance Abuse (MH/SA) Treatment
The Claims Administrator for MH/SA benefits is different from your Medical Claims Administrator.

Important: In order to receive MH/SA benefits, you must call the MH/SA Claims Administrator to precertify treatment. If you do not precertify treatment, you will not receive any benefits from the Plan, even if you use a network provider.

As with the HCN and PPO/Non-PPO, you can choose whether you use a network or non-network provider for your treatment. However, you’ll receive the most benefits when you use network providers (providers who participate in the MH/SA Claims Administrator’s network of mental health professionals and facilities).

Refer to the “How Mental Health and Substance Abuse (MH/SA) Treatment Coverage Works” section on Page 72 for more details. Refer to the “Mental Health and Substance Abuse (MH/SA) Claims Administrator” table on Page 119 for contact information and to Appendix D on Page 122 for additional precertification information.

Important: If you do not precertify treatment with the MH/SA Claims Administrator, you will not receive any benefits from the Plan, even if you use a network provider.

HMO or Other Alternative Managed Care Product
As an alternative under the CHCP, you may be able to enroll in an HMO or other alternative managed care product, if available in your area. A monthly contribution also may be required.

You will receive information about this alternative when you join the Company and during annual enrollment, which is usually held in the fourth quarter of each calendar year. You can enroll in an HMO or other alternative managed care product, if available in your area, within the same time frame that you enroll in the Plan.

If you elect coverage in an HMO or other alternative managed care product available in your area, you will not be eligible for any other coverage in the Plan, including but not limited to the HCN or PPO/Non-PPO and vice versa. You are also not eligible for the Plan’s prescription drug program, MH/SA treatment or the smoking cessation program “Free and Clear” administered by the Plan’s Prescription Drug Claims Administrator. Coverage for prescription drug and MH/SA will be administered through the HMO or other alternative managed care product. Contact your...
HMO or other alternative managed care product administrator for information on prescription
drug and MH/SA treatment benefits.

All family members must enroll in the same option. Refer to the “Eligible Dependents” section on
Page 58 to verify who can enroll.

Some dependents, such as sponsored children, Class II and dependents not living in your home
are not eligible to enroll in an HMO or other alternative managed care product. Also, not all
HMOs or other alternative managed care plans will allow you to enroll a Registered Domestic
Partner (RDP) or may request additional information before completing the enrollment.

If you choose to enroll in an HMO or other alternative managed care product available in your
area, you may be required to select a PCP from a list of network physicians and health care
facilities. Your PCP coordinates your health care to help you receive the level of care you need.

If you elect coverage with an HMO or other alternative managed care product, you are subject
to the benefits, terms and limitations of the particular HMO or other alternative managed care
product, so it is important that you get any questions you have answered by the HMO or other
alternative managed care product administrator, before you enroll.

Once enrolled in the HMO or other alternative managed care product, active employees must
remain in the HMO or other alternative managed care product until the next annual enrollment
period, unless they move out of the HMO or other alternative managed care product service
area or have a change in status event. For more information or to enroll, contact the Enrollment
and Eligibility Vendor.

**Important:** If you elect coverage under an HMO or other alternative managed care product and
the Enrollment and Eligibility Vendor enrolls a dependent that is eligible for coverage under the
Plan but the HMO or alternative managed care you elected later determines that the dependent
is not eligible for coverage under the particular HMO or alternate managed care product, you
may change your coverage retroactively to the beginning of the calendar year or the time of
your enrollment, if later, so that the dependent can be covered. However, you will be subject to
the terms of the Plan concerning the payment of benefits, including, for example, the level of
payments provided for non-network or non-PPO services. In addition, you may not be able to
change the amount being deducted on a pre-tax basis under the SBC Flexible Spending
Account Plan.

**Note:** Some HMOs or other alternative managed care products do not cover some dependents
that are eligible for coverage under the Plan, such as sponsored children, disabled, Class II and
dependents not living in your home. Also, not all HMOs or other alternative managed care
products will allow you to enroll a Registered Domestic Partner (RDP) or a disabled dependent
under the same terms and conditions as the Plan and/or may request additional information
before completing the enrollment. If you elect coverage with an HMO or other alternative
managed care product, you are subject to the benefits, terms and limitations of that particular
HMO or other alternative managed care product so it is important that you make sure any
questions you have are answered by the HMO or other alternative managed care administrator,
and that you know whether all of your dependents will be covered before you enroll.
Eligible Dependents

Your eligible dependents are:

- **Your spouse.**

- **Your Registered Domestic Partner (RDP),** that is, any individual with whom you have entered into a domestic partnership that has been registered with a governmental body pursuant to state or local law authorizing such registration.

- **Your unmarried dependent children**, until the end of the year they reach the age of 19, or the end of the month they turn the age of 25 if they are Full-time Students in an eligible Institution of Learning. Coverage for children who are Full-time Students ends on the last day of the month that the child graduates or leaves school, except due to illness or injury. If your child is continuously prevented from returning to school due to an illness or injury and loses eligibility as a dependent under the Plan their coverage will end on the last day of the month in which they turn the age of 25. A student is considered full-time if he or she is taking 12 or more credit hours per semester or the equivalent. If your child is no longer a Full-time Student you must call the Enrollment and Eligibility Vendor and advise them that your child is no longer eligible for coverage. The Enrollment and Eligibility Vendor will solicit for Full-Time Student verification. Refer to the “Enrollment and Eligibility Vendor” table on Page 114 for additional information on this process.

- **Your unmarried disabled children**, that is, your dependent children, regardless of age, who are incapable of self-support, physically or mentally handicapped and fully dependent on the employee or retiree for support.

- **Your sponsored children**, that is, any unmarried children between the ages of 19 and 25 who are not Full-time Students at an eligible Institution of Learning. Sponsored children have no restrictions on income or place of residence. To cover your sponsored children, they must be enrolled in the Plan and you must pay the cost of their coverage.

- **Class II dependents**, that is, your or your spouse’s unmarried dependent children, your unmarried grandchildren (who must be at least six months old), your brothers and sisters, and your or your spouse’s parents or grandparents who are currently enrolled in the Plan may be considered eligible dependents under the Plan if the dependent earns less than $12,000 annually from all outside sources, lives in a household provided by you in your vicinity for at least six months at the time a medical claim is filed, and are dependent on you for support.

*Note: As of Jan. 1, 1996, no new Class II dependents can be enrolled in the Plan. You must pay the cost of coverage for any currently enrolled Class II dependent(s). If your Class II dependent(s) is covered by the Plan and becomes eligible for Medicare, his or her Plan coverage will be discontinued. Coverage must be continuous. If coverage of a currently enrolled Class II dependent ceases for any reason, coverage cannot be reinstated.*

**“Children” include your own children, children placed for adoption in your home, legally adopted children or stepchildren (through marriage) or through your relationship with an RDP who live with you, and children for whom either you, your spouse/RDP is a Legal Guardian.**
Important: If your dependent does not meet the eligibility requirements under the Plan, the Plan will not pay any health care expenses for this dependent. You should also be aware that if the Plan has paid health care expenses for this dependent before the ineligibility is identified, you will be required to reimburse the Plan for all such expenses. Refer to the “Right of Recovery” section on Page 70 for additional information.

If You and Your Spouse/RDP Are Both Employed by or Retired From the Company

If you and your spouse/RDP are both employed by or receiving retirement benefits from the Company, you cannot be covered as an employee or retiree and as a dependent at the same time nor can any of your other eligible dependent(s), if applicable, be a covered dependent of both of you. Instead, you may:

- Enroll the entire family (including your spouse/RDP)
- Elect Individual Coverage and have your spouse/RDP enroll your dependent children
- Elect no coverage and have your spouse/RDP elect Individual plus one or Individual plus two or more coverage and enroll you and your children as covered dependents
- Split the dependents between you and your spouse/RDP

Important: You cannot be covered as an employee or Eligible Retiree and a dependent at the same time. No one can be a covered dependent of more than one active employee or retiree.

Change in Status Events

Under the Plan, if you have a change in status event, you are eligible to change your enrollment election during the year (i.e., outside of the annual enrollment period). A change in status event is when any of the following events occur:

- Marriage or registration of a Registered Domestic Partner (RDP)
- Divorce, legal separation, legal annulment or dissolution of a Registered Domestic Partnership
- Birth, adoption or placement for adoption
- Gain or loss of dependent status, custody or legal guardianship
- Qualification of a Qualified Medical Child Support Order
- Expiration of a Qualified Medical Child Support Order
- Death of a spouse/RDP, former spouse/RDP*, dependent, surviving spouse/RDP
- Gain or loss of spouse/RDP, or former spouse/RDP* employment or benefit coverage
- Home ZIP code change
- Change in full-time or part-time employment for employee, spouse/RDP or former spouse/RDP*
- Mid-year expiration of COBRA coverage
- Significant change in cost of spouse/RDP or former spouse/RDP* coverage
- Change in dependent care or health care cost or coverage attributable to a move, transfer or an event beyond the participant’s control
- Taking or returning from an unpaid leave of absence by the employee, spouse/RDP, or former spouse/RDP*

*A former spouse/RDP is not eligible for coverage under the Plan. However, if your eligible dependent is covered by your former spouse/RDP and your eligible dependent’s coverage is affected; this is considered a change in status event. Refer to the “Eligible Dependents” section on Page 58 for additional information.

Important: To be considered a change in status event, the event must result in the gain or loss of eligibility for coverage either under the CHCP or your spouse’s/RDP’s or dependent’s employer’s health plan. Any changes made to your coverage must also be consistent with the change in status event. For example, if you gain a dependent, you may change your coverage level from Individual to Individual plus one or Individual plus two or more coverage, but you could not change from Individual plus one to Individual or enroll yourself or other eligible dependents not previously enrolled.

You must change your enrollment election in these situations **within 31 days of the change in status event** for coverage to be effective on the date the change in status event occurs. Refer to the “Enrollment and Eligibility Vendor” table on Page 114 for contact information.

Refer to the SBC Flexible Spending Account Plan SPD for information concerning the potential effect, if any, of changes in enrollment made as a result of one of these events on your pre-tax deductions.

**How to Change Your Enrollment Due to a Change in Status Event**
You change your enrollment by contacting the Enrollment and Eligibility Vendor within 31 days of the change in status event. Refer to the “Enrollment and Eligibility Vendor” table on Page 114 for contact information.

**Prospective Enrollment**
If you miss the 31-day window, prospective enrollment allows you to enroll yourself and any eligible dependents at any time to your health care benefit elections, except as noted below, outside of the specified enrollment periods. When you do this, the effective date of the coverage will be the first day of the month following the date you request the change. Refer to the SBC Flexible Spending Account Plan SPD for more information on whether prospective enrollment will affect the amount of your pre-tax deduction, if any.

*Note: Once you are enrolled in the HCN, you will not be able to switch to an HMO, other alternative managed care product or the PPO/Non-PPO for the remainder of the calendar year, unless you experience a change in status event or are eligible for flexible enrollment*.

Remember, you cannot be covered as an employee or retiree and a dependent at the same time and no person can be a covered dependent of more than one active employee or retiree. Refer to the “Eligible Dependents” section on Page 58 for details about who qualifies as your eligible dependent.
*Eligible Retiree’s should refer to the “Mid-Year Changes (Flexible Enrollment)” section on Page 12 for more information.

**New Hire Eligibility**

If you are a Regular or Regular Limited Term full-time or part-time Employee, you are eligible to elect health care coverage under the CHCP for yourself and your eligible dependents beginning on your date of hire, provided you enroll within 31 days of your hire date.

If you elect coverage under the CHCP, you will pay the full cost of coverage until you become eligible for Company contributions as provided below. Any contributions will be deducted from your paycheck.

If you are a Regular or Regular Limited Term full-time or part-time Employee, you are eligible for Company contributions toward your coverage for you and your eligible dependents beginning the first day of the month in which you attain six months* of service, if, on that day, you are actively at work with the Company or receiving accident disability benefits under the Ameritech Sickness and Accident Disability Benefit Plan.

If you are hired by a Participating Company on or after Jan. 1, 2002, and you were previously retired from an SBC Company and are receiving post-employment (retiree) medical benefits under a plan sponsored by an SBC Company at the time you are rehired, you will continue to receive post-employment (retiree) medical benefits under the terms applicable to similarly situated retirees who have not been rehired.

**How to Enroll**

**For Coverage to be Effective From Your Date of Hire.** You must enroll through the Enrollment and Eligibility Vendor within 31 days of the later of your hire date, or the date you receive your enrollment materials for coverage, if you want coverage for yourself and any eligible dependents to be effective on your date of hire. You will pay the full cost of coverage until you become eligible for Company contributions as provided below. Refer to the SBC Flexible Spending Account Plan SPD for more information on whether enrollment will affect the amount of your pre-tax deduction, if any.

**For Coverage to be Effective on the First Day of the Month During Which You Complete Six Months* of Service.** You must enroll yourself and any eligible dependents through the Enrollment and Eligibility Vendor within 31 days of the later of your hire date or the date you receive your enrollment materials for coverage to be effective on the first day of the month during which you complete six months* of service (i.e., the date you become eligible for Company contributions).

**Default Coverage.** If you do not enroll in the CHCP within the 31-day period as described above, you will automatically be enrolled for Individual Coverage (for yourself) in either the HCN or PPO/Non-PPO option beginning the first day of the month in which you attain six months* of service with the Company, based on your home ZIP code*. For more information concerning how the Plan works, refer to the “How the Health Care Network (HCN) Works” section on Page 23 and the “How the PPO/Non-PPO Works” section on Page 35.
**Important:** You cannot be covered as an employee or retiree and a dependent at the same time. In addition, no one can be a covered dependent of more than one active employee or retiree. Refer to the “Eligible Dependents” section on Page 58 if you and your spouse/RDP are both employed by or retired from the Company.

*Through June 30, 2004, if you are covered under the collective bargaining agreement with CWA District 4, you are eligible for Company contributions toward coverage for you and your eligible dependents beginning the first day of the month in which you attain three months of service.

*Through June 26, 2004, if you are covered under the collective bargaining agreement with IBEW 21, you are eligible for Company contributions toward coverage for you and your eligible dependents beginning the first day of the month in which you attain three months of service.

*Through May 29, 2004, if you are covered under the collective bargaining agreement with AIS IBEW 21, you are eligible for Company contributions toward coverage for you and your eligible dependents beginning the first day of the month in which you attain three months of service.

**There are no mandatory ZIP codes (i.e., enrollment in the HCN is voluntary), in Illinois, Indiana, Ohio, Michigan or Wisconsin, whether or not the criteria is met as described in “The Health Care Network (HCN)” section on Page 20. This excludes employees covered by the collective bargaining agreement with IBEW 494.

**Prospective Enrollment.** If you miss the 31-day window, Prospective Enrollment allows you to enroll yourself and any eligible dependents at any time to your health care benefit elections, outside of the specified enrollment period. When you do this, the effective date of the coverage will be the first day of the month following the date you request the change. Refer to the SBC Flexible Spending Account Plan SPD for more information on whether prospective enrollment will affect the amount of your pre-tax deduction, if any.

Refer to the “Enrollment and Eligibility Vendor” table on Page 114 for contact information.

**Cost of Coverage**

**Regular or Regular Limited Term Full-Time Employee**
If you are a Regular or Regular Limited Term full-time Employee, the Company pays the full cost of your coverage effective the first day of the month during which you attain six months* of service with the Company, unless you elect coverage under an HMO or other alternative managed care product option, which may require a contribution.

**Regular or Regular Limited Term Part-Time Employee**
If you are a Regular or Regular Limited Term part-time Employee, you may be required to pay some or all of the cost of your and your dependents’ coverage, depending on the number of scheduled hours you work each week as described below.

- If your scheduled work week is 25 hours or more, or if you were hired on or before Dec. 31, 1980, and have been continuously employed by the Company since that date, the Company
pays the full cost of your coverage effective the first day of the month during which you attained six months* of service with the Company, unless you elect coverage under an HMO or other alternative managed care product option, which may require a contribution.

- If you were hired on or after Jan. 1, 1981, and,
  - Your scheduled work week is at least 17 but less than 25 hours, you pay half the cost of your coverage effective the first day of the month during which you attain six months* of service with the Company (if you elect coverage under an HMO or other alternative managed care product option, you are responsible for any contribution associated with that HMO or other alternative managed care product).
  - If your scheduled work week is less than 17 hours, you pay the entire cost of your coverage.

Note: The actual cost of coverage is determined annually. You will be advised of your cost of coverage for the alternatives available to you in your enrollment package when you are hired, at annual enrollment and at your request to the Enrollment and Eligibility Vendor. No CHCP Company contribution shall be provided to a newly hired Eligible Employee or any Eligible Dependents until the first of the month in which the newly hired Eligible Employee completes six months* of net credited service.

*Refer to “New Hire Eligibility” section on Page 61 for information on the temporary change in the time period for Company contribution eligibility.

When Your Coverage Ends

In general, CHCP coverage for you and your dependents will end on the earlier of:

- The last day of the month in which your employment ends, if you are not eligible for post-employment (retirement)* benefits
- The last day of the month in which you cancel coverage
- The last day of the month in which your eligibility for benefits under the Ameritech Long-Term Disability Plan (“LTD Plan”) ends

*Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for LTD and surviving spouse/RDP benefits as an active employee.

In addition, the Company retains the right to terminate coverage for Eligible Employees (and their covered dependents) who engage in a work stoppage.

If one of your dependents becomes ineligible for coverage, coverage will end on the last day of the month in which he or she becomes ineligible. A dependent that is reaching the age of 19 is covered until the last day of the year in which the dependent reaches the age of 19. A dependent who is a Full-time Student is covered until the end of the month in which the dependent reaches the age of 25 or until the end of the month in which he or she graduates or leaves school, whichever occurs first, except due to illness or injury. If your child is continuously prevented from returning to school due to an illness or injury and loses eligibility as a dependent
under the Plan their coverage will end on the last day of the month in which they turn the age of 25.

**Important:** If your child is no longer a Full-time Student you must call the Enrollment and Eligibility Vendor and advise them that your child is no longer eligible for coverage.

You or your dependents may be eligible to continue coverage as provided under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) after coverage would otherwise end. Refer to the “Extension of Coverage – COBRA” section on Page 87 for additional information about COBRA.

**Other Continuing Coverage Provisions**
Your HCN or PPO/Non-PPO coverage may continue (subject to limitations) after it would generally end, in the following situations.

- If you or a covered dependent are confined in a hospital when coverage ends, the Plan will continue to pay the patient’s Eligible Expenses for the confinement as long as they are Medically Necessary according to the terms of the Plan.
- If you are receiving benefits or are eligible to receive benefits under the LTD Plan, your CHCP coverage will continue as long as you remain eligible.
- In the event of your death, your spouse/RDP and certain dependents covered at the time of your death may elect to continue coverage for twelve months from the end of the month in which the employee dies, subsidized at the level of contribution that would have applied if the employee had remained alive.

For additional information contact the Enrollment and Eligibility Vendor. Refer to the “Enrollment and Eligibility Vendor” table on Page 114 for contact information.

**If You Are on an Approved Leave of Absence or Are Laid Off**

**Leave of Absence**
If you are on an approved leave of absence, you will receive a notice explaining what coverage you are eligible to continue and whether you will be required to pay for this coverage. If you do not continue coverage under the Plan while you are on your leave of absence, you must reenroll upon your return to work by contacting the Enrollment and Eligibility Vendor and speaking to a service associate. All coverages that continued while you were on leave will be continued when you return to work.

**Layoff**
COBRA coverage is available for up to 18 months. In certain circumstances the company will continue to subsidize your coverage for a period of time while you are on COBRA. For more specific information, refer to your applicable collective bargaining agreement for information concerning any time periods in which the Company may subsidize your COBRA coverage.

Eligible members of the CWA who are laid off from the Company and elect to participate in the Training Opportunity Plan (TOP) may be eligible for Company-paid coverage according to the applicable collective bargaining agreement.
Note: Subsidized extended medical coverage by the Company shall not extend the period of coverage beyond that required to be provided by COBRA.

If You Retire
You are eligible to continue coverage under the CHCP if you retire, except as noted below, from the Company with a service or disability pension under the Ameritech Pension Plan (APP).

If during your retirement, you acquire a newly eligible dependent, including a spouse/RDP, you can add that person to your coverage. There is no lifetime benefit maximum for the HCN network or the PPO/Non-PPO for you and your eligible dependent(s). A $500,000 HCN non-network maximum lifetime benefit limit applies to each retiree and each eligible dependent(s).

Refer to the Ameritech Pension Plan SPD for more information on the pension plan.

Note: Upon leaving the Company, an employee covered by the collective bargaining agreement with IBEW 494 is not eligible for post-employment (retirement) benefits, regardless of whether he or she is eligible for a service or disability pension. However, such an employee does qualify for long-term disability and surviving spouse/RDP benefits as an active employee.

If You Are Eligible for Medicare
You must enroll in Medicare Parts A and B, when you first become eligible (usually when you turn age 65) unless you are actively at work. Refer to the “If You Work Past the Age of 65” section for more details.

If you are receiving benefits under the LTD Plan and you receive a Social Security disability award, you will automatically be eligible for Medicare Parts A and B twenty-five months after your Social Security disability award begins. You also will be eligible for Medicare Parts A and B if you terminate employment before the age of 65 and subsequently become disabled and receive a Social Security disability award. In both cases, you must enroll in Medicare Parts A and B.

Medicare Part B Reimbursement
You and your spouse/RDP may be eligible for reimbursement by SBC for a portion of your monthly Medicare Part B premiums. The Enrollment and Eligibility Vendor will mail you enrollment information approximately 120 days before your 65th birthday. Contact the Enrollment and Eligibility Vendor if you do not receive this enrollment information within this timeframe or if you become Medicare-eligible as a result of a disability. Reimbursement for you or your spouse/RDP, if eligible, will not begin until the supporting documentation is received and processed by the Enrollment and Eligibility Vendor. Retroactive reimbursements are not available.

Important: Remember, you must enroll in Medicare Parts A and B when you first become eligible*. Medicare will provide your primary coverage and the Plan coverage will be secondary. Plan benefits will then be paid at the Non-PPO level. Regardless of whether you enroll in Medicare when you become eligible, benefits payable under the Plan will automatically be reduced by benefits payable for the same services under Medicare Parts A and B.
If you or a dependent are eligible for both Plan coverage and Medicare, precertification requirements do not apply to medical or MH/SA benefits. However, if you or your dependent is not eligible for Medicare, you or your dependent are still subject to precertification requirements for MH/SA treatments.

**If You Work Past the Age of 65**

If you remain actively at work after the age of 65 and are eligible for Medicare, the Plan will provide your primary coverage and Medicare coverage will be secondary. These provisions also apply to your spouse/RDP and other covered dependents as long as you are an active employee. If you choose Medicare as your primary coverage while you are still working, you and your spouse/RDP and other covered dependents will not receive any benefits from the Plan.

If you are Medicare-eligible when you retire, Medicare becomes your primary medical insurance on the first day of the month following your retirement date. You should enroll in Medicare Part B* before retiring to ensure coverage.

**Long-Term Disability**

Former employees receiving long-term disability benefits under the LTD Plan and other participants who are eligible for Medicare are covered by Non-PPO provisions. Precertification requirements do not apply if you are eligible for Medicare.

**If You Become Disabled Before the Age of 65**

If you terminate your employment before the age of 65, become disabled and, as a result, become eligible to receive a Social Security disability award, you will be eligible for Medicare Parts A and B as your primary coverage. If this is the case, you must enroll in Medicare Parts A and B as soon as you are eligible.

**End-Stage Renal Disease**

In the event you or your dependent begins kidney dialysis or has a kidney transplant, the CHCP will provide primary coverage during the first 30 months, after which Medicare will provide primary coverage. If you have any questions regarding coverage contact the Medical Claims Administrator.

**The Plan is Integrated With Medicare**

The Plan will not pay for benefits that you could receive from Medicare. Once you are eligible to enroll in Medicare, the Plan becomes your secondary coverage. Benefits that would be paid by Medicare Part A or B are subtracted from the benefits that would be paid under the Plan. If you have not enrolled for Medicare Part B, your provider can bill you for those amounts that neither Part B nor the Plan pays. This rule also applies to any Medicare-eligible dependents covered under your Company-offered plan.

*Important: The Plan is integrated with Medicare whether you enroll in Medicare or not.

Therefore, it is important that you understand your rights to Medicare and Medicare’s rules about Part A and B enrollment. Some information concerning Medicare follows. However, if you have questions concerning your Medicare eligibility and benefits, you should contact Medicare directly.
Understanding Medicare
Medicare provides coverage to certain eligible individuals via a two-part program:

- **Part A** – generally inpatient hospital expenses
- **Part B** – generally services of physicians’ or other non-hospital providers

Medicare establishes its own coverage rules concerning:

- When you become eligible
- Whether you must pay a premium for Part A
- How much you pay for Part B
- How benefits are paid

Qualifying for Medicare
Generally, if you are retired and at least 65 years of age, you are eligible for Medicare – *and Medicare becomes your primary coverage*. This means that Medicare will pay its benefits first, without requiring payment from other coverage you might have. Medicare also may become your primary coverage if you are eligible for Medicare due to disability and are no longer actively employed. In either case, once you become eligible for Medicare, the CHCP will become your secondary coverage and will not pay for any benefits covered by Medicare.

If you do not qualify for Part A coverage without having to pay a premium your benefits payable under the Plan will remain primary and will not be reduced for the Medicare benefits, as described below.

Some individuals, even if retired and at least the age of 65, may not qualify for Medicare Part A without having to pay a premium, if the number of quarters worked is not equal to at least the minimum number of quarters required by Medicare. However, some of these individuals may qualify as the spouse of a Medicare-eligible individual. If you do not qualify for Medicare Part A without having to pay a premium, you may choose to enroll by contacting Medicare and paying the required premium. If you are not sure if you qualify, contact Medicare or the Social Security Administration directly.

Even if you are not eligible for and do not enroll in Medicare Part A, you are eligible for Medicare Part B. To enroll in Part B you must contact Medicare and request enrollment within the required time period, i.e., the period beginning three months before your 65th birthday and through three months following the month of your 65th birthday. You should discuss these details with Medicare or the Social Security Administration directly.

Enrolling in Medicare Part A and Part B
If you qualify for Medicare coverage, about three months before your 65th birthday, Medicare will send you a Medicare card showing that you are entitled to both Part A and Part B benefits. Part A coverage is automatic and does not require payment of a monthly premium. *Remember, if you do not qualify for Medicare Part A without having to pay a premium, you may choose to enroll by contacting Medicare and paying the required premium.* Part B also is automatic, but does require payment of a monthly premium. However, because there is a premium involved, you may choose to not participate in Part B. If you choose to not participate in Part B, and later want to enroll in Part B, you may enroll only during Medicare’s General Enrollment Period – Jan.
1 through March 31 each year — and you may have to pay an additional monthly penalty of 10 percent of the usual premium for every 12-month period in which you could have been enrolled in Part B, but chose not to.

Medicare allows you to choose not to enroll in Part B without incurring the 10 percent penalty under some circumstances:

- If you are actively employed or are rehired beyond the age of 65, or if you have Medicare coverage due to a disability but are still actively employed, and have coverage through your employer’s group plan, you may postpone enrollment in Part B until you retire or otherwise lose active group coverage. There also would be no offset under the Plan for Medicare benefits, as Medicare would not be your primary coverage while you were employed.

- If your spouse is actively employed after you become Medicare-eligible (due to age or disability), and covers you under his or her employer’s group plan, you may postpone enrollment in Part B until your spouse retires or you otherwise lose active group coverage. There also would be no offset under the Plan for Medicare benefits, because Medicare would not be your primary coverage while you were covered under your spouse’s employer’s plan while he or she remains actively employed.

In these situations you may enroll for Part B, without penalty, during the eight months following the loss of your group coverage. Remember that you must contact Medicare to enroll — and if you miss the eight-month window you may have to wait until the next General Enrollment Period to enroll and pay the 10 percent penalty.

Although Medicare allows you an eight-month window after you lose group coverage to enroll in Part B, Medicare becomes primary again as soon as you lose your employer’s or your spouse’s employer’s group coverage. The Plan will begin to subtract benefits payable by Medicare as soon as you are eligible, whether you actually enroll at that time or wait until the end of the window. Medicare would become primary, for example, if your spouse retired, even though you remained covered as a dependent under your spouse’s employer’s plan.

Assistance With Medicare Questions
If you need assistance in understanding Medicare’s rules and regulations, you may contact Medicare toll free at 1-800-MEDICARE, or the Social Security Administration toll-free at 1-800-772-1213, or you may call your local Social Security Administration office. If you have access to the Internet, you may go to the Medicare Web site at www.medicare.gov or the Social Security Web site at www.ssa.gov. If you have questions about how the Plan integrates coverage with Medicare, you may contact the applicable Claims Administrator at the toll-free number on your identification card.

Filing a Claim
You, your covered dependents, or duly authorized persons, have the right under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the Plan to file a written claim for benefits under the Plan. The Claims Administrators listed in the back of this SPD are responsible for claims and appeal administration under the Plan. However, the Claims Administrators are not responsible for Plan financing nor do the Claims Administrators guarantee any Plan benefits under any contract or policy of insurance. The Plan is a
“self-insured plan,” which means Plan benefits are paid by the Company from its general assets and from the Voluntary Employees' Beneficiary Association Trust (VEBA).

If you need claim forms, contact the appropriate Claims Administrator. Refer to the “Contact Information” section on Page 104 for contact information and to Appendix D on Page 122 for additional information concerning the Plan’s claim and appeal procedures and your rights and responsibilities.

Claims Under the HCN

Network. You do not have to file a claim to receive network benefits; your provider will file a claim for you.

Non-network. If you use non-network services, you can file a claim in one of the following ways:

- Complete the appropriate form available from the Medical Claims Administrator and submit it, along with an itemized bill, to the Medical Claims Administrator.
- Request that your doctor or other health care provider send your bills directly to the Medical Claims Administrator. After the Plan pays your health care provider, you pay the balance of the bill. A separate claim form must be filed for each individual who receives services.

The Plan will monitor your expenses and note when you have met your deductibles and Coinsurance maximums. You will receive an explanation of benefits of the amount payable by the Plan if there are non-covered services or if you owe any money to the health care provider.

Important: You should keep copies of all receipts and bills for your records.

Claims Under the PPO/Non-PPO

PPO. You do not have to file a claim to receive PPO benefits — your provider will file a claim for you.

Non-PPO. When you incur Non-PPO medical expenses, you can pay your health care provider directly and then file a claim for reimbursement or your provider can send your bills directly to the Medical Claims Administrator. You will receive an explanation of benefits, which will state the amount payable by the Plan and will indicate if you owe any money to the provider. After the Plan pays you for the covered expenses, you are responsible for the amounts not paid for by the Plan.

The Plan will monitor your expenses and note when you have met your deductibles and Coinsurance maximums.

Important: You should keep copies of all receipts and bills for your records.

Claims for HMO or Other Alternative Managed Care Products

If you are enrolled in an HMO or other alternative managed care product, you cannot receive benefits offered by the HCN or PPO/Non-PPO. Contact the HMO or other alternative managed care product administrator directly for claim forms and procedures. For information on where to file a claim or appeal refer to the information you received from the applicable HMO or other
alternative managed care product administrator at the time of enrollment or refer to the “Contact Information” section on Page 104.

Claims for Prescription Drug Benefits
Refer to the “How Prescription Drug Coverage Works” section on Page 74 for more information about how to file a claim for prescription drug benefits.

Claims for Mental Health and Substance Abuse (MH/SA) Benefits
Refer to the “How Mental Health and Substance Abuse (MH/SA) Treatment Coverage Works” section on Page 72 for more information about how to file a claim for MH/SA benefits.

Claim Filing Limits
You must give the Claims Administrator written proof of loss within two years after the date the expenses are incurred. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, the Claims Administrator may request more information. No benefits are payable for claims submitted after the two-year period, unless it can be shown that it was not reasonably possible to submit the claim during the two-year period, or written proof of loss was given to the Claims Administrator as soon as was reasonably possible.

Right of Recovery
The Claims Administrator may pay benefits that should be paid by another plan, organization or person. In addition, benefits may be paid that are in excess of what should have been paid under this Plan. The Plan may recover the amount paid from the other plan, organization, person or yourself, if necessary.

Important: If one of your dependents does not meet the eligibility requirements under the CHCP, the Plan will not pay any health care expenses for that dependent. You should also be aware that if the Plan has paid health care expenses for this dependent before the ineligibility is identified, you will be required to reimburse the Plan for all such expenses.

Subrogation/Right of Reimbursement
If you are injured or disabled by the negligent or wrongful act or omission of a third party, the Plan will pay benefits but reserves the right to recover those payments from the person who injured you or his or her insurance company. Accordingly, if you recover, or have the right to recover, monies from any other source, for example other insurance coverage, uninsured, underinsured, homeowners, or umbrella insurance policies, the Plan, at its option, may make a claim for the funds previously paid. The Plan shall have a lien on any amounts recovered from any other source to the extent permitted by applicable law. The amount of money to be subrogated shall not be reduced by any legal fees or costs.

You are required to cooperate fully with the Claims Administrator or its agents in the exercise of such subrogation rights, including providing written information as requested. In addition, you must do nothing after loss to prejudice such rights and shall do everything necessary to secure such rights. If the Plan cannot subrogate, it will exercise its right of reimbursement.

If you recover any amount for your injury by way of a settlement or judgment in or out of a court of law, you are required to reimburse the Claims Administrator for the amounts paid under the Plan up to the amount recovered, without any reduction for legal fees or costs. The Plan shall have a lien upon any such recovery to the extent permitted by applicable law.
Coordination of Benefits

If you and/or your covered eligible dependent(s) are covered by another plan that provides medical benefits besides this one, benefits will be coordinated between the two plans.

Benefits will be coordinated as follows:

- If the other plan has no provision for coordination of benefits, that plan will pay covered benefits first (primary)

- If the other plan has a coordination provision, then the following provisions apply.
  - The plan covering the patient as an employee or retiree will pay benefits first (primary).
  - The plan covering the patient as a dependent will pay benefits according to the “Birthday Rule,” except as provided below in a divorce or legal separation or disillusionment of your Registered Domestic Partnership. Under the “Birthday Rule,” the plan of the person whose birthday (month and day of birth only, not year) occurs first in the calendar year will be considered primary.

If the patient is a child of divorced or legally separated parents or of a Registered Domestic Partnership that has been dissolved, the plan covering the parent whom has financial responsibility for the child’s health care as established by a court decree will pay first.

If there is no divorce decree or other court order that assigns financial responsibility, the plan of the parent who has custody of the child will cover the child first, the custodial step-parent’s plan (if any) will pay second, and the non-custodial parent’s plan will pay third. A non-custodial parent may be required to provide health care to a dependent child if a court issues a Qualified Medical Child Support Order (QMCSO). Refer to the “Qualified Medical Child Support Order” section on Page 96 for more information about QMCSOs.

If these guidelines do not apply, the plan covering the patient for the longer period of time will pay first.

When the Plan pays benefits first, benefits will be paid as specified in the Plan.

When the Plan pays benefits second, it will coordinate its benefits so the total amount reimbursed by both plans will equal the amount payable by the more generous of the two plans. The plans’ Claims Administrators will work together to determine which plan provides the greater benefits.

Note: If your spouse/RDP or former spouse/RDP is also employed by or retired from an SBC Ameritech company and enrolled in the CHCP, there is no coordination of benefits within the Ameritech family of Companies or between multiple Ameritech plans. Also, remember, you cannot be covered as an employee or retiree and a dependent at the same time. No one can be a covered dependent of more than one active employee or retiree. Refer to the “Eligible Dependents” section on Page 58 and the “If You and Your Spouse/RDP Are Both Employed by or Retired From the Company” section on Page 59 for more information.
How Mental Health and Substance Abuse (MH/SA) Treatment Coverage Works

The Plan provisions provide coverage for MH/SA treatment through the MH/SA Claims Administrator. When you call the MH/SA Claims Administrator, a wide range of resources will become available to you and your covered dependents, including help from psychiatrists, psychologists, psychiatric social workers, masters level nurses, hospitals, clinics, and substance abuse programs. The MH/SA Claims Administrator is not a crisis control center, but it can help you in emergency and non-emergency situations 24 hours a day, 365 days a year.

Important: You are not eligible for MH/SA benefits under the Plan if you elect an HMO or other alternative managed care product. Contact your HMO or other alternative managed care product administrator for more information.

Receiving Benefits

In order to receive MH/SA treatment benefits under the Plan, you must call the MH/SA Claims Administrator and precertify outpatient and non-emergency MH/SA services. **Without precertification, the Plan will not pay any benefits, even if you see a network provider.** **Precertification is not a determination of eligibility or a guarantee of payment.**

When you call the MH/SA Claims Administrator, a clinical care manager will assess your situation and provide you with a choice of at least two to three providers, if available. After you select a provider and make an appointment, you must again contact the MH/SA Claims Administrator so the provider you selected can be precertified. If you receive emergency hospital treatment and are admitted to the hospital for further treatment, you must call the MH/SA Claims Administrator within 48 hours after receipt of emergency services.

Important: If you do not notify the MH/SA Claims Administrator within 48 hours, the Plan will not pay any benefits. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Mental Health and Substance Abuse (MH/SA) Claims Administrator” table on Page 119 for contact information and Appendix D on Page 122 for additional precertification information.

What the Plan Pays

Your benefit level depends on whether you receive treatment from a network provider or from a provider not in the MH/SA Claims Administrator network and whether you received precertification from the MH/SA Claims Administrator to see the provider.

**Network.** When you use one of the providers the MH/SA Claims Administrator referred you to, your treatment will be covered at the network level. This means you will pay a $10 Copayment for each office visit, or a $60 Copayment per inpatient hospitalization or partial hospitalization. The Plan will cover any additional Eligible Expenses at 100 percent as determined by the MH/SA Claims Administrator. You do not need to file a claim form for payment; your provider will do this for you.

**Non-Network.** You will receive non-network benefits if you:

- See a provider that is not in the MH/SA Claims Administrator’s network
- Contact the MH/SA Claims Administrator to precertify your non-network care
After you precertify care with the MH/SA Claims Administrator the Plan will cover up to 75 percent of the R&C Fee for office visits and 75 percent of Eligible Expenses for inpatient confinements, up to a $75,000 lifetime maximum for mental health treatment with a non-network provider. You are responsible for the additional 25 percent, any expenses above the R&C Fee, and any ineligible expenses. If you reach the lifetime maximum, you can receive additional coverage by using network providers. Any costs above the R&C Fee do not apply to the Annual Out-of-Pocket Maximum.

Your provider may submit a claim on your behalf; however, you may need to file a claim form to receive benefits. Refer to Appendix B on Page 80 for a list of services, procedures or supplies requiring precertification. Refer to the “Mental Health and Substance Abuse (MH/SA) Claims Administrator” table on Page 119 for contact information and to Appendix D on Page 122 for additional precertification information.

**Important:** If you do not precertify your treatment with the MH/SA Claims Administrator, the Plan will not pay any benefits, even if you use a network provider.

**Substance Abuse Treatment**

Whether you or a covered dependent use network or non-network services, only two courses of substance abuse treatments are covered per individual per lifetime, but the non-network lifetime maximum of $75,000 per individual for mental health treatment does not apply. A second course of treatment occurs if, after initiating treatment, you or a covered dependent stop treatment and then require additional treatment 90 or more days after terminating from the program.

*Note:* Detoxification treatment by itself does not become a part of the two courses of allowed treatment under this Plan and is covered under the medical portion of the Plan. Detoxification that is followed by additional substance abuse treatment (e.g. inpatient, residential treatment, partial hospitalization, intensive outpatient programs) constitutes a course of treatment. Therefore detoxification plus substance abuse treatment equals an episode. Substance abuse treatment by itself counts as an episode, but detoxification with no follow-up substance abuse treatment services does not count as an episode.

**Important:** Your MH/SA benefits depend on whether you receive network or non-network services. You may need to file a claim to receive reimbursement if non-network services are used. The table below also lists the MH/SA Annual Out-of-Pocket Maximum by Level of Coverage. **Remember, if you do not precertify your treatment with the MH/SA Claims Administrator, the Plan will not pay any benefits, even if you use a network provider.**

<table>
<thead>
<tr>
<th><strong>MENTAL HEALTH AND SUBSTANCE ABUSE (MH/SA) TREATMENT BENEFITS</strong></th>
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<tbody>
<tr>
<td><strong>PLAN FEATURE</strong></td>
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<tr>
<td>Annual Deductible</td>
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<tr>
<td>Outpatient Treatment</td>
</tr>
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MENTAL HEALTH AND SUBSTANCE ABUSE (MH/SA) TREATMENT BENEFITS

<table>
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<tr>
<th>PLAN FEATURE</th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
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<tr>
<td>Inpatient Treatment</td>
<td>100% of Eligible Expenses after $60 Copayment per admission if certified by the MH/SA Claims Administrator — if not precertified, no coverage</td>
<td>75% of Eligible Expenses if certified by the MH/SA Claims Administrator — if not precertified, no coverage</td>
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</table>
| Annual Out-of-Pocket Maximum¹ | - $250 per Individual
- $500 for Individual plus one or Individual plus two or more | - $1,000 per Individual
- $2,000 for Individual plus one or Individual plus two or more |
| Mental Health Treatment Lifetime Maximum² | None | $75,000 per Individual |
| Substance Abuse Treatment Lifetime Maximum | 2 courses of treatment | 2 courses of treatment |
| Emergency Room Treatment | 100% of Eligible Expenses after $25 Copayment. If admitted, $25 Copayment applies to $60 Copayment and you must call the MH/SA Claims Administrator within 48 hours to precertify — if not precertified, no coverage | 100% of Eligible Expenses after $25 Copayment. If admitted, $25 Copayment applies to $60 Copayment and you must call the MH/SA Claims Administrator within 48 hours to precertify — if not precertified, no coverage |

¹After you meet the Annual Out-of-Pocket Maximum, benefits will be paid at 100 percent of Eligible Expenses. This Annual Out-of-Pocket Maximum is separate from your HCN or PPO/Non-PPO Annual Out-of-Pocket Maximum and from the prescription drug Annual Out-of-Pocket Maximum.

²Upon meeting the non-network lifetime maximum; a covered person may incur eligible network expenses.

How Prescription Drug Coverage Works

Prescription drug coverage is an important part of your HCN or PPO/Non-PPO health care coverage. All Plan participants enrolled in the HCN or PPO/Non-PPO receive coverage for short-term and long-term prescription drugs through the Prescription Drug Claims Administrator.

Important: HMO or other alternative managed care product participants are not covered under this plan. Contact your HMO or other alternative managed care product administrator for information about the HMO’s or other alternative managed care product’s prescription drug coverage, if available.

Short-Term Prescriptions (Up to a 30-day Supply)

Prescriptions for up to a maximum of 30 days, with one refill up to 30 days, are considered short-term prescriptions. The Plan will reimburse 90 percent of Eligible Expenses for the cost of short-term prescriptions, after you meet the Annual Deductible. After you reach the Annual Out-of-Pocket Maximum, the Plan pays for the entire cost of Eligible Expenses for prescriptions and refills. The following table lists the short-term Annual Deductible and Annual Out-of-Pocket Maximum by Level of Coverage.
**Short-Term Prescription Benefit Features**

| Annual Deductible<sup>1, 2</sup> | ▪ $25 per Individual  
|----------------------------------|------------------
|                                  | ▪ $50 for Individual plus one or Individual plus two or more  
| Annual Out-of-Pocket Maximum<sup>1, 2</sup> (includes deductibles) | ▪ $100 per Individual  
|                                  | ▪ $200 for Individual plus one or Individual plus two or more  

<sup>1</sup>Refer to the “Definitions” section on Page 82 to find out how the Annual Deductible and Annual Out-of-Pocket Maximum are met.  
<sup>2</sup>Separate Annual Deductibles and Annual Out-of-Pocket Maximums apply for HCN, PPO/Non/PPO and MH/SA expenses.

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**Claiming Short-Term Prescription Drug Benefits**

*If you are an active employee and not covered by the collective bargaining agreement with IBEW 494,* you may fill your short-term prescriptions at any pharmacy, but are required to file a claim form to receive benefits. You should:

- Have the prescription(s) filled at any pharmacy  
- Pay 100 percent for the prescription  
- Submit the completed claim form and original receipt to the Prescription Drug Claims Administrator for reimbursement of 90 percent of Eligible Expenses

You generally will receive your reimbursement within 14 days after the Prescription Drug Claims Administrator receives your claim form and receipt. A new claim form will be sent to you with the Explanation of Benefits (EOB) that accompanies your reimbursement check.

*If you are covered by the collective bargaining agreement with IBEW 494 or are retired, you must:*  

- Participate in the Claims Administrator’s Prescription Drug Card Program  
- Use the Prescription Drug Claims Administrator’s network pharmacy to receive coverage for these benefits  
- Pay 10 percent of Eligible Expenses and any applicable deductibles (the Plan will pay 90 percent of Eligible Expenses)

To locate the network pharmacy that is closest to you, contact the Prescription Drug Claims Administrator. When filling your prescription, bring your prescription and Prescription Drug Claims Administrator’s ID card to your network pharmacy. The pharmacist will collect the applicable Coinsurance amount and file a claim on your behalf.

**Important:** Long-term prescriptions (31 days up to a maximum of 90 days) are not covered when purchased at a retail pharmacy.
Note: Covered prescription drugs are dispensed subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances, and the manufacturer’s recommendations.

Long-Term Prescriptions (31 Days up to a Maximum of 90 Days)
The Prescription Drug Claims Administrator’s Mail Service Prescription Drug Program fills and refills long-term prescriptions (31 days up to a maximum of 90 days) and mails your medication directly to your home at no additional cost. There is no annual deductible, however, a Copayment may apply as explained below.

Claiming Long-Term Prescription Drug Benefits
For active employees or retired employees who are not covered by the collective bargaining agreement with IBEW 494. You should include the following with your order when filling your initial long-term prescription through the Mail Service Prescription Drug Program.

- Your original prescription
- The completed order form to the Prescription Drug Claims Administrator

The Prescription Drug Claims Administrator keeps your prescription on file and will provide reordering information with your initial prescription. There are three ways to request a refill of your long-term prescription:

- Internet – Provide the information sent to you with the first fill of your initial prescription
- Telephone – Provide the employee’s or retiree’s Social Security Number and year of birth
- Mail – Provide the completed order form from the Prescription Drug Claims Administrator

Note: The refill date and number of refills remaining is noted on your last prescription. The Prescription Drug Claims Administrator cannot refill any prescription before that date, nor can they refill any prescription if there are no remaining refills.

Your order will be processed and shipped to you via UPS or First Class U.S. Mail. You should generally receive it within 14 days after the Prescription Drug Claims Administrator receives your order. Reordering information will be enclosed with each shipment.

For employees covered by the collective bargaining agreement with IBEW 494. You should include the following with your order when filling your initial prescription through the Mail Service Prescription Drug Program.

- Your original prescription
- The completed order form to the Prescription Drug Claims Administrator
- Applicable Copayment:
  - $5 for each generic medication
  - $15 for each brand medication

The Prescription Drug Claims Administrator keeps your prescription on file and will provide reordering information with your initial prescription. There are three ways to request a refill of your long-term prescription:
Internet – Provide the information sent to you with the first fill of your prescription
Telephone – Provide the employee’s or retiree’s Social Security Number and year of birth
Mail – Provide the completed order form from the Prescription Drug Claims Administrator
Applicable Copayment:
- $5 for each generic medication
- $15 for each brand medication

Note: The refill date and number of refills remaining is noted on your last prescription. The Prescription Drug Claims Administrator cannot refill any prescription before that date, nor can they refill any prescription if there are no remaining refills.

Your order will be processed and shipped to you via UPS or First Class U.S. Mail. You should generally receive it within 14 days after the Prescription Drug Claims Administrator receives your order. Reordering information will be enclosed with each shipment.

Note: Covered prescription drugs are dispensed subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances, and the manufacturer’s recommendations.

Refer to the “Prescription Drug Claims Administrator” table on Page 115 for contact information and additional information concerning the Prescription Drug Claims Administrator’s Mail Service Drug Program’s claim and appeal procedures.

What is a Generic Drug?
A generic drug is considered equivalent to the brand name drug because its active chemical composition is substantially identical, although the drug may vary in color, size, or shape.

All generic drugs dispensed by the Prescription Drug Claims Administrator are bioequivalent, meaning they are absorbed by the body at the same rate as the brand name drug.

Note: The Prescription Drug Claims Administrator promotes the use of generic equivalents whenever possible. The Prescription Drug Claims Administrator may fill your prescription with a generic if it is not marked “Dispense As Written.” Even if the prescription contains this stipulation, a change to a generic equivalent may be made if the Prescription Drug Claims Administrator’s pharmacist contacts your physician and obtains his or her consent. If the physician does not approve the change, your prescription will be filled as originally written.

What the Prescription Drug Program Covers
Examples of covered items include:
- Diabetic supplies
  - Insulin
  - Syringes
  - Blood and urine test strips
  - Lancets
• Alcohol swabs
  ▪ Oral contraceptives
  ▪ Contraceptive Injectables (if Medically Necessary)
  ▪ Retin A (if patient is age 35 or younger or if Medically Necessary at any age)
  ▪ Vitamins that require a prescription
  ▪ Pre-natal vitamins when prescribed as a result of a diagnosis (only through the mail service program)
  ▪ Smoking cessation program (*Free and Clear Program*) - The CHCP will cover charges for participating in a smoking cessation program offered under the CHCP for covered persons age 18 or older (limited to two 12-month enrollments per lifetime)
  ▪ Weight loss medications (if Medically Necessary), *precertification required through the Prescription Drug Claims Administrator*

*Note: As with all provisions of the Plan, the Company reserves the right to make changes to this list.*

Refer to the “Prescription Drug Claims Administrator” table on Page 115 for contact information.

**What the Prescription Drug Program Does Not Cover**

Items not covered under the Prescription Drug Program include, but are not limited to:

  ▪ Products not requiring a prescription by law
  ▪ Over-the counter medication (such as aspirin, medicated shampoo, chlor-trimeton, etc.)
  ▪ Minoxidil (Rogaine) and Propecia
  ▪ Nicotine Replacement Therapy, Nicorette gum, Nicoderm patches, and similar items (except if approved in conjunction with the smoking cessation program offered under the Plan for covered persons age 18 and older)
  ▪ Zyban (except if approved in conjunction with the smoking cessation program offered under the Plan for covered persons age 18 and older)
  ▪ Nutritional and diet supplements
  ▪ Retin A (if patient is age 36 or older unless Medically Necessary)
  ▪ Renova
  ▪ Vitamins (except vitamins that require a prescription)
  ▪ Charges for experimental or Investigational drugs, or substances not approved for marketing by the U.S. Food and Drug Administration (FDA) or for drugs labeled “Caution – limited by Federal law to investigative use”
  ▪ Batteries

*Note: As with all provisions of the Plan, the Company reserves the right to make changes to this list.*
Appendix A: Outpatient Procedures

Below are the procedures which, if performed on an outpatient basis, are covered at 100 percent of Eligible Expenses if:

- You are covered under the Health Care Network (HCN) and use network services, or
- You are covered under the PPO/Non-PPO and obtain precertification before the procedure is done.

If you are covered under the PPO/Non-PPO, the deductible does not apply and you must obtain precertification before the procedure is done.

If you use non-network services, the following procedures are covered at 75 percent.

- Bunionectomy (repair of bunion deformity on great toe)
- Cardiac catheterization (diagnostic procedure passing a catheter into the heart through a blood vessel)
- Carpal tunnel repair (relief of nerve pressure in wrist)
- Closed reduction of bone fracture
- Dilation and curettage (D&C or scraping of the uterus)
- Hemorrhoidectomy (removal of hemorrhoids)
- Inguinal hernia repair (repair of a tear in the muscle wall separating the groin and abdominal cavity)
- Lithotripsy (removal of kidney stone)
- Pilonidal cyst removal (removal of a cyst located near the base of the spine)
- Submucous resection (removal of a portion of the nasal septum)
- Stapedectomy (removal of the stapes bone of the ear)
- Tonsillectomy/adenoidectomy (removal of tonsils/adenoids)
- Venography (X-raying of veins injected with dye)

**Important:** If you do not obtain precertification when required before receiving PPO/Non-PPO or non-network services, having a procedure done or obtaining supplies, the Plan will pay $250 less than would otherwise be payable. *In some cases the Plan will not pay any benefits.* For contact and additional precertification information refer to the “Contact Information” section on Page 104 and Appendix D on Page 122.

**Note:** As with all provisions of the Plan, the Company reserves the right to make changes to this list.
Appendix B: Precertification

Precertification is required to receive full coverage of certain services, procedures or supplies, or for others, to receive any coverage at all. If you are in the HCN, your network PCP will work with you to coordinate your care for you to be covered by network benefits, and you generally do not need to precertify. If you elect to use non-network services or you live in an area where a network is not available and you are covered by PPO/Non-PPO provisions, you must obtain precertification before receiving certain services. Precertification is not a determination of eligibility or a guarantee of payment.

Important: If you do not obtain precertification when required before receiving PPO/Non-PPO or non-network services, having a procedure done or obtaining supplies, the Plan will pay $250 less than would otherwise be payable. In some cases the Plan will not pay any benefits. Refer to the “Contact Information” section on Page 104 for the applicable Claims Administrator’s information and to Appendix D on Page 122 for additional precertification information.

HCN
If you are enrolled in the HCN and you use non-network physicians or services, you must obtain precertification in the following situations:

- At least 10 days before a scheduled non-emergency medical hospital admission, surgical hospital admission or surgical procedure in an Ambulatory Surgical Center
- Within 48 hours after an emergency
- An extended obstetrical hospital admission (beyond 48 hours for a vaginal delivery and 96 hours for a cesarean delivery)
- Before obtaining Approved Home Care Agency, Hospice Care, or Skilled Nursing Facility (otherwise, the HCN will not pay any benefits)
- Before using air ambulance or air transport in non-emergency situations
- Before a Type A Procedure organ transplant (Type B Procedures performed by a non-network provider and/or at a non-network facility are not covered)
- Before receiving surgical treatments for TMJ
- Before having an outpatient procedure listed in Appendix A on Page 79

PPO/Non-PPO
If you are covered by PPO/Non-PPO provisions, you must obtain precertification in the following situations:

- At least 10 days before a scheduled non-emergency medical hospital admission, surgical hospital admission or surgical procedure in an Ambulatory Surgical Center
- Within 48 hours after an emergency
- An extended obstetrical hospital admission (beyond 48 hours for a vaginal delivery and 96 hours for a cesarean delivery)
- Before obtaining Approved Home Care Agency, Hospice Care, or Skilled Nursing Facility (otherwise, the PPO/Non-PPO will not pay any benefits)
- Before having an outpatient procedure listed in Appendix A on Page 79
- Before any organ transplant procedures (otherwise, the PPO/Non-PPO will not pay any benefits)
- Before using air ambulance or air transport in non-emergency situations
- Before receiving surgical treatments for TMJ

**MH/SA**
All MH/SA treatment must be precertified to receive any benefits.

*Note: As with all provisions of the Plan, the Company reserves the right to make changes to this list.*
Definitions

**Ambulatory Surgical Center.** An Ambulatory Surgical Center is a specialized facility that has been licensed as an ambulatory surgical center in accordance with the applicable laws in the jurisdiction in which it is located by the state’s regulatory authority as being established, equipped, operated and staffed primarily for the purpose of performing surgical procedures.

**Annual Base Pay.** Annual Base Pay includes your base pay plus commissions for the prior Plan year and excludes overtime, bonuses, success sharing incentives, team incentives, and merit or other awards.

**Annual Deductible.** The Annual Deductible is the amount of covered expenses that you pay each calendar year before the HCN or PPO/Non-PPO begins to pay benefits. Charges that are considered ineligible under the Plan are not considered to be part of your Annual Deductible, for example, charges in excess of the R&C Fee and charges not covered under the CHCP. Your Annual Deductible is based on your Annual Base Pay as defined above. If you have Individual coverage for yourself only, you pay expenses up to the Individual deductible amount before the Plan begins to pay benefits. If you have Individual plus one coverage, each individual must meet the Individual deductible. If you have Individual plus two or more coverage, your deductible can be satisfied in one of two ways: you can pay for covered expenses for one family member up to the Individual deductible; then, the covered expenses of the remaining family members are combined to satisfy the remainder of the Individual plus two or more deductible; or the Individual plus two or more deductible can be satisfied when covered expenses for all family members reach the Individual plus two or more deductible (even if this happens before one family member reaches the Individual deductible, as long as at least two members have covered expenses).

**Annual Out-of-Pocket Maximum.** The Annual Out-of-Pocket Maximum is the maximum amount of deductibles, if applicable and Copayment/Coinsurance that you will pay out of your own pocket each year for Eligible Expenses. For example, Copayment/Coinsurance for doctors’ office visits, hospital admissions, and emergency room treatments are included in your Annual Out-of-Pocket Maximum. MH/SA treatment expenses, prescription drug expenses, expenses that exceed the R&C or PPO Fees, and ineligible expenses are not included. No one covered family member pays more than the Individual Annual Out-of-Pocket Maximum. If you have Individual coverage for yourself only, you pay expenses up to the Individual Annual Out-of-Pocket Maximum before the Plan begins to pay benefits. If you have Individual plus one coverage, each Individual must meet the Individual Annual Out-of-Pocket Maximum. If you have Individual plus two or more coverage, your Annual Out-of-Pocket Maximum can be satisfied in one of two ways; you can pay for deductibles, if applicable, and Copayment/Coinsurance for one family member up to the Individual Annual Out-of-Pocket Maximum; then, the deductibles, if applicable, and Copayment/Coinsurance of the remaining family members are combined to satisfy the remainder of the Individual plus two or more Annual Out-of-Pocket Maximum; or the Individual plus two or more Annual Out-of-Pocket Maximum can be satisfied when deductibles, if applicable and Copayments/Coinsurance for all family members reach the Individual plus two or more Annual Out-of-Pocket Maximum (even if this happens before one family member reaches the Individual Annual Out-of-Pocket Maximum, as long as at least two members have deductibles, if applicable, and Copayments/Coinsurance).

**Annual Pension.** Your Annual Pension is your actual monthly pension multiplied by 12 (months).
**Approved Home Care Agency.** An Approved Home Care Agency is a public or private agency that specializes in giving nursing and other therapeutic services in the covered person’s home provided that the agency is licensed as such by a state department or agency having authority over health home agencies. It includes skilled nursing care, therapist and Approved Home Care Agency aide home visits, nutrition therapy, and medical supplies prescribed by a physician.

**Approved Transplant Facility.** An Approved Transplant Facility is a facility designated by the Medical Claims Administrator to render necessary eligible qualified procedures under this Plan for certain transplant procedures.

**CHCP.** CHCP refers to the entire range of health care coverages available under the Ameritech Comprehensive Health Care Plan, including:

- The Health Care Network (HCN)
- The Preferred Provider Organization (PPO/Non-PPO)
- A health maintenance organization (HMO), if available in your area
- Other alternative managed care product, if available in your area

**Claims Administrator.** A Claims Administrator is an organization not related to the Company, specializing in the administration of health care benefits and management of claims, authorized by the Company to perform these functions for the CHCP.

**Class I Dependents.** Class I Dependents are defined as the Eligible Employee’s or Eligible Retiree’s:

- Spouse/RDP
- Unmarried dependent children until the end of the year in which they reach the age of 19 or end of the month in which they reach the age of 25 if the unmarried dependent child is a Full-time Student at an Institution of Learning
- Unmarried physically or mentally handicapped children financially dependent on the Eligible Employee or Eligible Retiree for support regardless of their age

*Note: “Children” include the Eligible Employee’s or Eligible Retiree’s own children, legally adopted children (including those in the process of being adopted), stepchildren who reside in the household of the Eligible Employee or Eligible Retiree and children for whom the Eligible Employee, Eligible Retiree, spouse/RDP is the legal guardian.*

**Coinsurance.** After you have met your Annual Deductible, except when there is a specified Copayment, you will pay a certain percentage of the cost of covered services. The amount that you pay is called “Coinsurance”. The Plan covers the remaining percentage of the Eligible Expenses.

**Copayment.** A Copayment is the amount specified under the CHCP that you must pay toward Eligible Expenses. Ineligible expenses are not considered part of your Copayment.

**Custodial Care.** Custodial Care refers to services that do not require that they be provided by skilled medical or nursing professionals to be safely performed. Custodial care consists of, but is
not limited to, maintaining or serving primarily to support personal hygiene, nutrition or other forms of self-care, rather than to provide medical treatment.

**Durable Medical Equipment.** Durable Medical Equipment refers to equipment that can stand repeated use, is used primarily for a medical purpose, and is appropriate for use in the home and generally not useful to a person in the absence of sickness or injury.

**Eligible Employee.** An Eligible Employee means a regular or term, full-time or part-time non-salaried employee (whose position is subject to automatic wage progression or whose pay is not determined on a monthly or annual basis) of a Participating Company who is not covered by another Company health plan and who is (1) actively at work; or (2) receiving Sickness or Accident Disability Benefits under the Ameritech Sickness and Accident Disability Benefit Plan; or (3) on an approved leave of absence from a Participating Company. For purposes of this definition, “non-salaried employee” includes (a) an employee in a bargaining unit represented by a union which has agreed to CHCP coverage, or (b) any other non-salaried employee to whom the Company has extended CHCP coverage; provided that, subject to any applicable collective bargaining agreements, the Company, in its sole discretion, may include one or more groups of salaried employees or exclude one or more groups of non-salaried employees from the term “Eligible Employee.” Subject to the limitations described in the “When Your Coverage Ends” section on Page 63, “Eligible Employee” also means the surviving spouse of any Eligible Employee described in any of items (1) through (3) above. Any other provision of the CHCP to the contrary notwithstanding, no individual will be considered an Eligible Employee nor will such individual be otherwise eligible to participate in or receive benefits under the CHCP during the period in which such individual is providing services to a Participating Company under a contract, arrangement or understanding with either such individual or with an agency or leasing organization that treats the individual as either an independent contractor or an employee of such agency or leasing organization, even if such individual is later determined (by judicial action or otherwise) to have been a common law employee of a Participating Company rather than an independent contractor or an employee of such agency or leasing organization.

**Eligible Expenses.** Eligible Expenses are expenses or charges (or portion thereof) incurred for Medically Necessary covered services, treatments or supplies recommended by the physician that are determined by the Claims Administrator to be within the amount provided under an applicable contractual arrangement with the respective provider of the service, treatment or supply, or the applicable R&C Fee.

**Eligible Retiree.** An Eligible Retiree includes:

- An Eligible Employee who retires from a Participating Company with a service pension or a disability pension under the Ameritech Pension Plan
- An Eligible Employee who terminates employment from a Participating Company and then begins receiving benefits under the Ameritech Long-Term Disability Plan
- An Eligible Employee who terminates employment from a Participating Company after receiving 52 weeks of Sickness Disability Benefits under the Ameritech Sickness and Accident Disability Benefit Plan and who, at the time, has 15 or more years of service with one or more Participating Companies
- Subject to the limitations described in the “When Your Coverage Ends” section on Page 63, the surviving spouse/RDP of any Eligible Retiree described in any of the items above.
**Experimental Procedures.** Experimental Procedures are techniques that as of the date of the procedure have been confined to laboratory and/or animal research.

**Full-Time Student.** Full-time attendance will be interpreted to include continuous coverage during normal vacations, e.g., summer, semester breaks, etc. at an Institution of Learning (as defined below). The child will cease to qualify as a Full-time Student as defined because of graduation or otherwise leaving school for reasons other than illness or injury.

**HCN.** HCN refers to the Health Care Network.

**Hospice Care.** The hospice must meet specific Plan requirements including state licensing and/or Medicare hospice certification and the provision of 24-hour per day care to control the symptoms of the terminal illness to be covered under the Plan. Care designed for terminally ill (life expectancy of six months or less) patients and their families is considered Hospice Care. It includes doctor, nurse, social worker, clergy, psychologist, psychiatrist, and other professional services, as well as counseling for family members after the patient dies.

**Institution of Learning.** Any accredited high school, college or university or other bona fide educational institution such as nursing schools, trade schools, etc., having an established curriculum for full-time (12 hours or more per school term) students. Correspondence schools, night schools, schools requiring less than full-time attendance and apprentice programs are not considered Institutions of Learning.

**Investigational.** Procedures, treatments or products which are received by a Covered Person as part of a controlled trial to prove safety and efficacy for purposes of approval by a government agency are considered Investigational. Drugs and medical devices are no longer considered Investigational upon approval by the Food and Drug Administration or other appropriate governmental organization. Procedures not subject to Food and Drug Administration approval will no longer be considered Investigational when supported for dissemination by consensus panels of the National Institutes of Health and/or supported by a substantial body of peer reviewed scientific literature. Use of procedures, treatments and products for purposes other than those originally designated shall be considered Investigational unless supported by substantial scientific evidence.

**Level of Coverage.** The Plan offers the following three Levels of Coverage:

- **Individual** — You enroll only yourself
- **Individual plus one** — You enroll yourself and one eligible dependent (such as your spouse/RDP or an eligible child)
- **Individual plus two or more** — You enroll yourself and two or more eligible dependents

**Medical Necessity.** Refer to the definition of “Medically Necessary” below.

**Medically Necessary.** A specific medical, health care or hospital service or supply is Medically Necessary if, in the reasonable medical judgment of the Claims Administrator, the service or supply is required for the treatment or management of a medical symptom or condition and the service or care provided is the most efficient and economical care or service which can be safely provided. Charges will not be considered Medically Necessary when diagnosis, care, or treatment is of unproven or questionable value; unnecessary when performed in combination
with other care; custodial in nature; unlikely to provide a Physician with additional information when used repeatedly; or not ordered by a Physician. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not itself, make that service or supply Medically Necessary. For MH/SA treatment to be considered Medically Necessary, the treatment also must:

- Be adequate and essential for evaluation and/or treatment of a condition or illness, as defined by standard diagnostic criteria
- Be reasonably expected to improve an individual’s condition or level of functioning
- Meet national standards which are defined by clinical references, valid empirical experience for efficacy, and/or national professional standards
- Be provided in the most independent, appropriate setting

**Network.** A network is a network of providers, hospitals, pharmacies and other health care providers established by the Claims Administrator. The providers, hospitals, pharmacies and other health care providers may change from time to time.

**Network Provider Contracted Fee.** A Network Provider Contracted Fee refers to charges for services rendered by or on behalf of a network provider in an amount not to exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

**Non-network.** Non-network refers to a provider, hospital, pharmacy and other health care provider that does not belong to the network.

**Non-PPO.** Non-PPO refers to a provider, hospital and other health care provider that does not belong to the PPO.

**Participating Company.** Participating Company means the Company and/or subsidiary, affiliate or business unit of the Company that has formally elected to participate in the CHCP.

**Pension Equivalent.** Pension Equivalent refers to the monthly immediate single life annuity or joint and survivor annuity, whichever is applicable, upon which the lump sum was calculated.

**PPO (Preferred Provider Organization).** A PPO is a group of providers, hospitals and other health care providers established by the Claims Administrator who have agreed to charge a negotiated rate for their services and who belong to the PPO. The providers, hospitals and other health care providers may change from time to time.

**PPO Fee.** A PPO Fee is determined by the Claims Administrator and based on the fee the provider usually accepts for a similar service and the range of fees other providers of similar training and experience in the same geographical area accept for the similar service.

**PCP (Primary Care Physician).** A physician in general practice or who specializes in pediatrics, family practice or internal medicine that has agreed with the Medical Claims Administrator to act as the entry point to the health care delivery system and as the coordinator of member care. The PCP is not an agent or employee of the Medical Claims Administrator.
Plan. Plan refers to the Company-offered health care coverages available under the CHCP, i.e., the HCN and the PPO/Non-PPO coverage options (as well as prescription drugs and MH/SA). It does not include HMOs or other alternative managed care products.

R&C Fee (Reasonable & Customary Fee). The R&C Fee is determined by the Claims Administrator based on the fee usually charged by your doctor or other health care provider to most patients for a similar service and the range of fees charged by doctors or other health care providers with similar training and experience in the same geographic area for similar services under similar circumstances. The applicable R&C Fee determined by the Claims Administrator may limit your benefit.

Regular Employee. A Regular Employee is an employee who is classified in Company records as a Regular Employee.

Regular Limited Term Employee. A Regular Limited Term Employee is an employee who is classified in Company records as a Regular Limited Term Employee.

Skilled Nursing Facility. A Skilled Nursing Facility is an institution, other than a hospital, which is licensed according to state and local laws and is operated primarily for the purpose of providing 24-hour skilled nursing care and treatment for individuals convalescing from illness or injury.

Extension of Coverage – COBRA

The Consolidated Ominbus Reconciliation Act of 1974, as amended (“COBRA”) is a Federal law which requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances when coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that SBC may maintain and that provides medical care coverage or a vehicle for reimbursement of payment for such coverage. The CHCP is a group health plan subject to COBRA. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay the entire premium for your continuation coverage. At the end of the maximum coverage period (described in this section), you will be allowed to enroll in an individual conversion health plan if it is otherwise available under the Plan, subject to the requirement to pay the premiums required by the individual conversion health plan.

This section provides a brief overview of your rights and obligations under current law.

COBRA Qualifying Events

Employee/Retiree. If you are an employee/retiree of a Participating Company and are covered by the CHCP, you have the right to elect continuation coverage if you lose coverage under the CHCP because of any one of the following two “qualifying events”:

- Termination of your employment (for reasons other than gross misconduct)
- Reduction in the hours of your employment
Spouse/RDP. If you are the spouse/RDP of an employee/retiree covered by the CHCP, you have the right to elect continuation coverage if you lose coverage under the CHCP because of any of the following four “qualifying events”:

- The death of your spouse/RDP.
- A termination of your spouse’s/RDP’s employment (for reasons other than gross misconduct) or reduction in your spouse’s/RDP’s hours of employment with the Participating Company.
- Divorce from your spouse or dissolution of your registered domestic partnership. (Also, if an employee eliminates coverage for his or her spouse/RDP in anticipation of a divorce or dissolution, and a divorce or dissolution occurs, then the later divorce or dissolution will be considered a qualifying event even though the ex-spouse/partner lost coverage earlier. If the ex-spouse/partner notifies the Enrollment and Eligibility Vendor within 60 days after the later divorce or dissolution and can establish that the coverage was eliminated earlier in anticipation of the divorce or dissolution then COBRA coverage may be available for the period after the divorce or dissolution).
- Your spouse/RDP becomes entitled to Medicare benefits.

Dependent Child. In the case of a dependent child of an employee/retiree covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the CHCP is lost because of any of the following five “qualifying events”:

- The death of the employee/retiree-parent
- The termination of the employee-parent’s employment (for reasons other than gross misconduct) or reduction in the employee-parent’s hours of employment with the Employer
- Parents’ divorce or dissolution
- The employee/retiree-parent becomes entitled to Medicare benefits
- The dependent ceases to be a “dependent child” under the CHCP

Your Important Notice Obligations
If your spouse, RDP or dependent child loses coverage under the Plan because of divorce, dissolution or the child’s losing dependent status under the CHCP, then you (the employee/retiree) or your spouse/RDP or dependent has the responsibility to notify the Enrollment and Eligibility Vendor of the divorce, legal separation, or the child’s losing dependent status. You or your spouse/RDP or dependent must provide this notice no later than 60 days after the date coverage terminates under the CHCP, which is generally at the end of the month in which the qualifying event occurs (see the eligibility section of the applicable summary plan description for details regarding when plan coverage terminates). If you or your spouse, RDP or dependent child fails to provide this notice to the Enrollment and Eligibility Vendor during this 60-day notice period, any spouse, RDP or dependent child who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your spouse, RDP or dependent child fails to provide this notice to the Enrollment and Eligibility Vendor, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, dissolution or a child’s losing dependent status, then you, your spouse, RDP and dependent children will be required to reimburse the Plan for any claims so paid.
If the Enrollment and Eligibility Vendor is provided with timely notice of a divorce, legal separation, or a child’s losing dependent status that has caused a loss of coverage, then the Enrollment and Eligibility Vendor will send a COBRA notice to the last known address of the dependent.

The Enrollment and Eligibility Vendor will also notify you (the employee), your spouse and dependent children of the right to elect continuation coverage after the Enrollment and Eligibility Vendor receives notice of the following events that result in a loss of coverage:

- The employee’s termination of employment (other than for gross misconduct)
- Reduction in hours, or
- Death, or
- Employee’s becoming entitled to Medicare

**COBRA Election Procedures**

You (the employee/retiree) and/or your spouse/RDP and dependent children must elect continuation coverage within 60 days after CHCP coverage ends, or, if later, 60 days after the Enrollment and Eligibility Vendor mails, to your last known address, a notice of the right to elect continuation coverage. *If you or your spouse/RDP and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* You (the employee/retiree) and/or your spouse/RDP and dependent children may elect continuation coverage for all qualifying family members or you; your spouse/RDP and dependent children may elect continuation coverage individually. Thus, a spouse/RDP or dependent child may elect continuation coverage even if the covered employee/retiree does not elect it. If you become covered under another employer-sponsored group health plan or become entitled to Medicare, you lose your eligibility for continuation coverage; however your spouse/RDP and dependent children may elect continuation coverage.

**Type of Coverage**

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse/RDP or dependent children had on the day before the qualifying event. Therefore, an employee/retiree, spouse/RDP or dependent child who is not covered under the CHCP on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage is modified for similarly situated employees/retirees or their spouses/RDPs or dependent children, then COBRA coverage will be modified in the same way.

You (or your spouse/RDP or dependent children) may elect COBRA coverage under one or more of the benefits plans offered by SBC under which you are covered on the day of the qualifying event. For example, if you are covered under three separate employer plans (e.g., a medical plan, a dental plan, and a vision plan), you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. If you participate in a health flexible spending arrangement under which you are reimbursed for medical expenses, you (or your spouse, RDP or dependent children) may elect to continue the health FSA coverage under COBRA, but only if there is a positive account balance (i.e., year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). COBRA coverage under the health FSA will continue only for the remainder of the Plan year in which the qualifying event occurred. If there
is a negative account balance (i.e., year-to-date contributions are less than year-to-date claims), then no election to continue the health FSA can be made.

COBRA Premiums
The premium payments for all Qualified Beneficiaries for the first months of coverage must be paid by the 45th day following the election to continue coverage. Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums, which are due on the 1st of each month subject to a 60-day grace period. A premium payment that is mailed is considered to be made on the date it is postmarked. If you don’t make the full premium payment by the due date or within the 60-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month, with no possibility of reinstatement.

Maximum Coverage Periods
The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the “Termination of COBRA Coverage Before the End of the Maximum Coverage Period” section on Page 91.

- **36 Months.** If you (the spouse/RDP or dependent child) lose group health coverage because of the employee/retiree’s death, divorce or the employee’s becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse/RDP and dependent child) is 36 months from the date of the qualifying event.

- **18 Months.** If you (the employee, spouse/RDP or dependent child) lose group health coverage because of the employee’s termination of employment (other than for gross misconduct) or reduction in hours, the maximum continuation coverage period (for the employee, spouse/RDP and dependent child) is 18 months from the date of termination or reduction in hours. There are three exceptions:
  
  - If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Enrollment and Eligibility Vendor within 60 days following the determination of the disability by the Social Security Administration and the participant must still be within their 18-month coverage period.
  
  - If a second qualifying event (such as the death of the employee or a divorce when the maximum coverage period becomes 36 months) occurs within the 18-month or 29-month coverage period, then the maximum coverage period (for a spouse/RDP or dependent child) becomes 36 months from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Enrollment and Eligibility Vendor within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.
• If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse/RDP and dependent child) ends three years from the date the employee became entitled to Medicare.

**Shorter Maximum for Health FSAs**
The maximum COBRA period for a health flexible spending arrangement (health FSA) maintained by the Company (if there is a positive account balance as of the date of the qualifying event, as explained in the “Type of Coverage” section on Page 89) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative account balance as of the date of the qualifying event, no COBRA coverage will be offered.

**Children Born to or Placed for Adoption With the Covered Employee/Retiree During COBRA Period**
A child born to, adopted by or placed for adoption with a covered employee/retiree during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee/retiree is a qualified beneficiary, the covered employee/retiree has elected continuation coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the CHCP, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee/retiree. To be enrolled in the CHCP, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, age).

**Annual Enrollment Rights and HIPAA Special Enrollment Rights**
Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at annual enrollment. In addition, HIPAA’s special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for eligible dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under the “Children Born to or Placed for Adoption With the Covered Employee/Retiree During COBRA Period” section, dependents who are enrolled in a special enrollment period or annual enrollment period do not become qualified beneficiaries. Their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

**Alternate Recipients Under Qualified Medical Child Support Orders**
A child of yours (the employee’s/retiree’s) who is receiving benefits under the CHCP pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Enrollment and Eligibility Vendor during your (the employee’s/retiree’s) period of employment with the Participating Company is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

**Termination of COBRA Coverage Before the End of Maximum Coverage Period**
Continuation coverage of the employee/retiree, spouse/RDP and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

- The Company no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary’s COBRA coverage is not paid within the allowable grace period.
- After electing COBRA, you (the employee/retiree, spouse/RDP or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan.
- After electing COBRA coverage, you (the employee/retiree, spouse/RDP or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- You (the employee/retiree, spouse/RDP or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that would permit termination of coverage for cause with respect to covered employees/retirees or their spouses/RDPs or dependent children who have coverage under the Plan for a reason other than the COBRA coverage required by federal law.

You Must Notify Us About Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes
If you or your dependent’s address changes, you must promptly notify the SBC Pension and Savings Plan Service Center. Also, if your marital status changes or if a dependent ceases to be eligible for coverage under the Plan terms, you or your spouse or dependent must promptly notify the Enrollment and Eligibility Vendor in writing. Such notification is necessary to protect COBRA rights for your spouse and dependent children. In addition, you must notify us if a disabled employee or family member is determined to no longer be disabled.

Plan Administrator
SBC Communications Inc.
P.O. Box 29690
San Antonio, TX 78229

For More Information
Contact the Enrollment and Eligibility Vendor if you, your spouse/RDP or dependent children have any questions about this notice or COBRA.

Conversion of Coverage
COBRA Coverage
Upon cessation of COBRA coverage, you and your eligible dependents may convert to individual (non-group) coverage without a physical examination within 31 days after COBRA coverage ends. Contact the Enrollment and Eligibility Vendor for more information.
LTD Coverage
Conversion is also available if you were receiving benefits under the LTD Plan and your CHCP coverage ceases because you become ineligible for benefits under the LTD Plan for reasons other than reaching the age of 65 or a later applicable age (as provided in the LTD Plan SPD).

Mandatory Portability Agreement (MPA)
The Mandatory Portability Agreement (MPA) covers employees who, on Dec. 31, 1983, were in a covered position with a former Bell System company. If the MPA is applicable to you and modifies your length of service and/or your date of hire, the MPA could affect certain provisions of the Plan. For more information on the MPA and whether you are covered under its terms, please contact the Service Bridging Administrator. Refer to Page 121 for the Service Bridging Administrator’s telephone number.

ERISA Rights of Participants and Beneficiaries
Your ERISA Rights
As a participant in the SBC Umbrella Plan No. 1 (Ameritech Non-management Umbrella Welfare Benefit Plan - The Comprehensive Health Care Plan), 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 Plan.
- 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 Pension and Welfare Benefit 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, 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, and 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. Participants or beneficiaries should write to the Plan Administrator.
- Receive a summary of the CHCP annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse/RDP or dependents if there is a loss of coverage under the CHCP as a result of a qualifying event (refer to the “COBRA” section under the “Other CHCP Plan Information” section on Page 95). You or your dependents may have to pay for such coverage. Review this SPD, the SPD for the Plan and the documents governing the Plan or this Program, or the rules governing your COBRA continuation coverage rights.
Reduction or elimination of exclusionary periods of coverage for preexisting conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 employer, 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, other Plan 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, which 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. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue 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 Pension and Welfare Benefits Administration.
Other CHCP Plan Information

The following pages describe some additional information about the Plan and various laws that may impact your right to benefits under the CHCP.

COBRA
A federal law, known as the Consolidated Omnibus Reconciliation Act of 1974, as amended ("COBRA"), requires that you be given an opportunity to temporarily continue your participation in the Plan if you experience a “qualifying event.” A qualifying event is termination of your employment (other than for gross misconduct), reduction of your work hours, your death, divorce or legal separation from your spouse, or dissolution of your Registered Domestic Partnership your becoming entitled to Medicare benefits, or when a dependent of yours ceases to be a dependent. For a qualifying event other than a change in your employment status, it is your obligation to inform the Enrollment and Eligibility Vendor of its occurrence within 60 days of the occurrence. The Enrollment and Eligibility Vendor, in turn, has a legal obligation to furnish you, your spouse/RDP, as the case may be, with separate, written options to continue the benefit coverages provided at the stated costs with respect to each group health plan benefit in which you are a participant. Your right to continued participation under COBRA requires you to contribute toward the cost of your continued coverage. A detailed description of your COBRA rights and obligations, including, among other things, information concerning qualifying events. Qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage under this CHCP are provided in the “Extension of Coverage – COBRA” section on Page 87.

Newborns’ and Mothers’ Health Protection Act
To the extent this Plan provides benefits for hospital lengths of stay in connection with childbirth, the Plan will cover the minimum length of stay required for deliveries (i.e., a 48-hour hospital stay after a vaginal delivery or a 96-hour stay following a delivery by Cesarean section.) The mother's or newborn's attending physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by law. No provider authorization is required from the Plan or any Claims Administrator for prescribing a length of stay less than 48 or 96 hours. This coverage is subject to any applicable deductible or Copayment/Coinsurance amounts.

Women’s Health and Cancer Rights Act
An individual who is receiving mastectomy benefits under this Plan and who elects breast reconstruction in connection with the mastectomy will receive coverage for reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance, any needed prosthesis, and coverage for physical complications of all stages of the mastectomy, including lymphedemas. This coverage is subject to any applicable deductible or Copayment/Coinsurance amounts.

Mental Health Parity Act
To the extent this Plan provides mental health benefits, it will not place annual or lifetime maximums on those benefits which are lower than the annual and lifetime maximum dollar limits for physical health benefits. This coverage is subject to any applicable deductibles and Coinsurance, as well as lifetime maximums.
Privacy of Health Information
The Health Insurance Portability and Accounting Act ("HIPAA") provides you with certain rights in connection with the privacy of your health information. Beginning April 14, 2003, ("implementation date") you automatically will receive a summary of these rights from either the Plan Sponsor or a program administrator. Additionally, you may receive a free copy of this information at any time after the implementation date, upon request.

Qualified Medical Child Support Orders (QMCSOs)
Generally, your benefits under the CHCP may not be assigned or alienated. However, an exception applies in the case of a qualified medical child support order (QMCSO). Basically, a QMCSO is an administrative agency or court-ordered judgment, decree, order, or property settlement agreement in connection with a state domestic relations law which either creates or extends the rights of an "alternate recipient" to participate in a plan that provides group health benefits, or enforces certain laws relating to medical child support. An "alternate recipient" is any child of a participant who is recognized by a medical child support order as having a right to enrollment under a participant's plan for group health benefits.

A medical child support order has to satisfy certain specific conditions to be qualified. The Plan Administrator or Enrollment and Eligibility Vendor will notify you if the Company receives a medical child support order that applies to you. You also will be provided a copy of the CHCP’s procedures for determining whether the medical child support order is qualified.

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order. The amount you will be required to pay under the CHCP for medical benefits in order to comply with the QMCSO may be changed to reflect the addition of the child. If a QMCSO is issued for your child and you are eligible but not participating in the CHCP at that time, you must enroll in the CHCP and pay any applicable contributions. Contact the Enrollment and Eligibility Vendor to add you and your child if you are not currently enrolled.

If the Plan Administrator or Enrollment and Eligibility Vendor receives a valid QMCSO, the Enrollment and Eligibility Vendor will extend coverage to the child(ren) named in the order. If you are the subject of a QMCSO, you will be notified once the order is received and you will be required to pay any applicable premiums for this medical coverage. If you would like a copy of the procedures governing QMCSOs, free-of-charge, contact the Enrollment and Eligibility Vendor.

HIPAA Certification
HIPAA places limits on preexisting condition exclusion periods and requires that your employer provide you with a written confirmation of your health care coverage under a plan, if applicable. In order to reduce the preexisting condition limitation period, you must provide proof of your prior "creditable coverage." Creditable coverage includes coverage under a plan for a self-insured employer group health plan, an individual or group health insurance indemnity or HMO plan, a state or federal continuation coverage plan, individual or group health conversion plans, Part A or Part B of Medicare, Medicaid (except for coverage for pediatric vaccines), the Indian Health Service, the Peace Corps Act, a state health benefits risk pool, a public health plan, health coverage for current or former members of the armed forces and any dependents, medical savings accounts, and health insurance for federal employees and any dependents.
Proof of creditable coverage is generally demonstrated through a certificate generated by your prior plan, which shows evidence of your prior health coverage. However, if you cannot obtain a certificate, you may demonstrate creditable coverage if you:

- Attest to the period of creditable coverage,
- Present corroborating evidence of some creditable coverage for the period (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms ("EOBs"), or verification by a doctor or former health care benefits provider that the individual had prior health coverage), and
- Cooperate in verifying the information provided.

You also may demonstrate proof of dependent creditable coverage without a certificate if you:

- Attest to such dependency and the period of such status as a dependent, and
- Cooperate with the verification of dependent status.

If you leave the Company and are hired by another employer that has a preexisting condition limit in its health care plan, you will need to provide proof of prior health care coverage to offset the limit. If you lose coverage under a plan that provides health care benefits that is offered by the Company, you are entitled to a certificate that shows evidence of your prior health coverage.

A certificate automatically will be issued should you lose your health care coverage. In addition, a certificate will be provided to you promptly upon request. If you need a certificate, please contact the Enrollment and Eligibility Vendor.

The certificate is used to determine preexisting condition exclusion periods, because under HIPAA, your period of coverage under any health care plan will offset the exclusion period of a new health care plan as long as you have not had a break in coverage over 63 days. The waiting period before your effective date of coverage does not count as a break in coverage.

If you lose coverage, you automatically will receive written certification that identifies:

- Individuals covered under the CHCP
- Period of coverage
- Any waiting periods

This certification is provided when:

- You leave the Company
- You or your dependent loses coverage
- Your or your dependent’s COBRA coverage ends
- You request it up to 24 months after you leave the Company
- You or your covered dependent becomes eligible for coverage under another plan

If you leave employment with the Company and obtain coverage under another health care plan, check with your new plan’s administrator to determine whether that plan has a preexisting condition exclusion period.
condition exclusion and if you need to provide a certificate or other information regarding your prior health care coverage or benefits.

CHCP Plan Administration

Plan Administrator
The Plan Administrator is the named fiduciary of the CHCP and has the power and duty to do all things necessary to carry out the terms of the CHCP. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the CHCP, to make findings of fact, determine the rights and status of participants and others under the CHCP, and decide disputes under the Plan and to delegate all or a part of this discretion to third parties. 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 CHCP.

Administration
The Plan Administrator has contracted with third parties for certain functions, including but not limited to, the processing of benefits and claims related thereto. In carrying out these functions, these third party administrators have been delegated responsibility and discretion for interpreting the provisions of the Plan, making findings of fact, determining the rights and status of participants and others under the Plan, and deciding disputes under the Plan. The tables provided in the "Contact Information" section beginning on Page 104 indicate the functions performed by each third-party contractor as well as the name, address and telephone number of each contractor.

Nondiscrimination in Benefits
The IRS does not allow discrimination in favor of highly compensated participants or key employees with regard to some of the benefits offered under the CHCP. The Plan Administrator may restrict the amount of nontaxable benefits provided to key employees or highly compensated participants so that these nondiscrimination requirements are satisfied.

Benefits provided under this Plan will not discriminate in any of the following ways:

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

Amendment or Termination of the CHCP
SBC intends to continue the CHCP described within this SPD, but reserves the right to end or amend the CHCP at any time and for any reason.

SBC has and reserves the right to amend or terminate the CHCP or amend or eliminate benefits under the CHCP at any time, subject to any applicable collective bargaining agreements with respect to employees covered by such an agreement and their dependents. In addition, your employing company (or the company that you retired from) reserves the right to end its participation in the CHCP. In any such event, you and other CHCP participants may not be eligible to receive benefits as described in this SPD, and you may lose benefit coverage. However, no amendment or termination of the CHCP will diminish or eliminate any claim for any benefit to which you may have become entitled prior to termination unless the termination or amendment is necessary for the CHCP to comply with the law.
Although no CHCP amendment or termination will affect your right to any benefit to which you have already become entitled, this does not mean that you or any other active or retired employee will acquire a lifetime right to any CHCP benefit, or to eligibility for coverage under the CHCP, or to the continuation of the CHCP merely by reason of the fact that the CHCP was in effect during your employment or at the time you received a benefit under the CHCP or at any time thereafter.

**Limitation of Rights**
Participation in the CHCP does not give you a right to remain employed at any SBC company.

**Legal Action Against the CHCP**
If you wish to bring a legal action concerning your right to participate in the CHCP or your right to receive any benefits under the CHCP, you must first go through the claim and appeal process described in this SPD. A legal action should not be filed until you complete the claim and appeal process. Legal action involving the CHCP should be filed directly against the CHCP. Process in legal actions concerning the provision of benefits under the CHCP should be served on the Plan Administrator as provided in the “CHCP Plan Information” table below.

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<td><strong>Plan Name</strong></td>
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<td><strong>Plan Sponsor and Plan Administrator (as defined by ERISA)</strong></td>
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<td><strong>Name and Address of Employer</strong></td>
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| | United HealthCare Insurance Company  
| | 450 Columbus Boulevard  
| | Hartford, CT 06103 |
| | SBC Communications Inc. administers claims and appeals for medical benefits under the PPO/Non-PPO provisions on a contract basis with: |
| | Blue Cross and Blue Shield of Illinois  
| | 300 E. Randolph Street  
| | Chicago, IL 60601 |
| | SBC Communications Inc. administers claims and appeals for prescription drug benefits under the Plan on a contract basis with: |
| | Caremark, Inc.  
| | 2211 Sanders Road  
| | Northbrook, IL 60062 |
| | SBC Communications Inc., administers claims and appeals for MH/SA benefits under the Plan on a contract basis with: |
| | *ValueOptions*  
| | 12369 Sunrise Valley Drive  
| | Reston, VA 20191 |
| | SBC Communications Inc., manages enrollment, eligibility and COBRA under the CHCP, included the determination of initial claims and appeals, on a contract basis with: |
| | Hewitt Associates LLC  
| | 100 Half Day Road  
<p>| | Lincolnshire, IL 60069 |</p>
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<tr>
<td><strong>Plan Funding and Contributions</strong></td>
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<tr>
<td>CHCP Plan Information</td>
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<tr>
<td><strong>Payment of Benefits</strong></td>
</tr>
<tr>
<td><strong>CHCP Records</strong></td>
</tr>
<tr>
<td><strong>Collective Bargaining Plan</strong></td>
</tr>
</tbody>
</table>
Appendix C: List of Participating Companies

The following lists the companies participating in the CHCP. Please note that eligibility or the level of benefits may vary within Participating Companies.

- Illinois Bell Telephone Company
- Indiana Bell Telephone Company, Inc.
- Michigan Bell Telephone Company
- The Ohio Bell Telephone Company
- Wisconsin Bell, Inc.
- Ameritech Services, Inc.
- Ameritech New Media, Inc.
- Ameritech Corporation
- SBC Global Service, Inc. (formerly known as Ameritech Information Systems, Inc.)
- Ameritech Publishing Inc.
- APIL Partners Partnership
- Ameritech Communications, Inc.
- SBC Services, Inc. - Ameritech
- Southwestern Bell Communications Services, Inc.

While all of the above companies participate in the CHCP, the provisions described are applicable to employees of the Company who are covered by the collective bargaining agreements between the CWA District 4, IBEW 21, AIS IBEW21 and IBEW 494 and the Company and Eligible Retirees who are covered under these collective bargaining agreements at the time of their retirement.

This SPD does not cover bargained-for employees of SBC Global Services, Inc. AIS IBEW 134 or AIS IBEW 58; Ameritech Communications, Inc.; Ameritech Publishing, Inc.; APIL Partners Partnership; and Southwestern Bell Communications Services, Inc.
Contact Information

Who Should I Contact if I Have Questions, Need to File a Claim or File an Appeal?
The tables on the following pages provide you with contact information for the different Claims
Administrators and Vendors, including for the:

- Medical Claims Administrators (Blue Cross and Blue Shield of Illinois [BCBSIL] and
  UnitedHealthcare [UHC])
- HMO Contact Information (SBC Connect)
- Enrollment and Eligibility Vendor (SBC Connect)
- Prescription Drug Claims Administrator (Caremark)
- MH/SA Claims Administrator (ValueOptions)
- Pension and Service Bridging Administrator (Mellon HR Solutions)

Important Coverage Information
In general, Blue Cross and Blue Shield of Illinois (BCBSIL) will be your Medical Claims
Administrator if you are in the PPO/Non-PPO. UnitedHealthcare (UHC) will be your Medical
Claims Administrator if you are enrolled in the HCN.

However, if you elect the HCN option for yourself and your dependent is living away from
home, outside of the network area and is approved as PPO/Non-PPO or, if you or your
dependent are Medicare-eligible and in the Non-PPO portion of the PPO/Non-PPO option,
UHC will be the Medical Claims Administrator for the entire family.

Note: If your dependent’s option is different from the option you choose for yourself, you must
call SBC Connect to enroll your dependent.

Important: PPO/Non-PPO providers and facilities will vary by Medical Claims Administrators.

<table>
<thead>
<tr>
<th>Medical Claims Administrators</th>
<th>If Blue Cross and Blue Shield of Illinois (BCBSIL) Is Your Medical Claims Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Reach a Service Associate</td>
<td>1-800-621-7336</td>
</tr>
<tr>
<td>Monday through Friday</td>
<td>PPO/Non-PPO</td>
</tr>
</tbody>
</table>
**MEDICAL CLAIMS ADMINISTRATORS**

**IF BLUE CROSS AND BLUE SHIELD OF ILLINOIS (BCBSIL) IS YOUR MEDICAL CLAIMS ADMINISTRATOR**

<table>
<thead>
<tr>
<th>For Precertification (MED-CALL) Monday through Friday</th>
<th>1-800-621-0965</th>
</tr>
</thead>
</table>
| If you are enrolled in the PPO/Non-PPO, you must contact BCBSIL’s MED-CALL if you need hospitalization, surgery, second opinions, Approved Home Care Agency care, Hospice Care, and Skilled Nursing Facilities. Please refer to your SPD for more information on precertification. **If you don’t contact MED-CALL for precertification, a $250 penalty will be applied in some cases before you receive any reimbursement or in some cases the service may not be covered.**  

**Precertification is not a determination of eligibility for benefits or participation in the Plan.**  

A registered nurse will:  

- Answer your questions and guide you through your particular situation  
- Precertify recommended hospitalizations, surgeries (inpatient and outpatient) and other services  
- Determine if the setting for treatment is appropriate  

You will need to provide information listed on your ID card, as well as information about the recommended surgery or hospitalization. The nurse may contact your physician to obtain additional information.  

**Important:**  
When enrolled in the PPO/Non-PPO, a $250 penalty will be applied in some cases before you receive any reimbursement or in some cases the service may not be covered if you don’t call MED-CALL in advance of a surgery or hospitalization (inpatient or outpatient) or other services or within the first 48 hours after an emergency hospital admission.  

For information concerning the Plan’s procedures for precertification claims and appeals, refer to *Appendix D* on Page 122.
| How to File a Claim | If you use a PPO provider, the provider will file a claim for benefits on your behalf. If you use non-PPO providers, you may have to file a claim. Information concerning the Plan’s procedures for submitting and processing claims and appeals from denied claims can be found in *Appendix D* on Page 122.

An Explanation of Benefits (EOB) will be sent to you with each claim that is processed.

Claim forms are available through:

- The SBC company employee benefits intranet site at [http://intranet.sbc.com/benefits/](http://intranet.sbc.com/benefits/) (for active employees who have access to the intranet)
- SBC’s secure Internet site at [http://access.sbc.com](http://access.sbc.com) (from home)
- [www.bcbsil.com/sbc](http://www.bcbsil.com/sbc)
- BCBSIL at 1-800-621-7336

Mail claims to:

BCBS of Illinois  
P.O. Box 1364  
Chicago, IL 60690-1364

*Remember to keep a copy for your records.* |
| For Appeals | BCBS of Illinois  
Attention: Appeals Coordinator  
3405 Liberty Drive  
Springfield, IL 62704 |
<table>
<thead>
<tr>
<th><strong>Medical Claims Administrators</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If Blue Cross and Blue Shield of Illinois (BCBSIL) Is Your Medical Claims Administrator</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Internet Access</strong></td>
<td>BCBSIL provides an online service at <a href="http://www.bcbsil.com/sbc">www.bcbsil.com/sbc</a> that allows you to access information about your health plan. When you access <a href="http://www.bcbsil.com/sbc">www.bcbsil.com/sbc</a> for the first time, you will be asked to register. Within five to seven days after registering, you will receive a password in the mail. Once you've received your password, you can:</td>
</tr>
</tbody>
</table>
|  | - Locate a BCBSIL PPO provider nationwide  
|  | - Verify enrollment  
|  | - Check claim status  
|  | - Print out copies of your EOBs  
|  | - Request an ID card  
<p>|  | - Download claim forms |
| <strong>Healthy Expectations Program</strong> | The Healthy Expectations Program is a benefit offered by BCBSIL. To participate you must contact MED-CALL during your first trimester (the first 12 weeks of pregnancy). The Healthy Expectations Nurse will contact you and conduct a short confidential questionnaire over the phone. Educational materials will be sent to you based on the individual needs assessed from your answers. The nurse will continue to be available to answer your questions and offer advice throughout your pregnancy. For participating in the program you will be mailed a voucher for a free car seat along with your educational materials. |
| <strong>BCBSIL Medicare Crossover Program</strong> | If BCBSIL is your Claims Administrator and you are Medicare-Primary, BCBSIL automatically enrolls you in its timesaving program called Medicare Crossover at no additional cost. This program allows Medicare to send information directly to BCBSIL each time Medicare Part A or B pays a provider's bill for your medical care. This eliminates the need for you to send a copy of the provider's bill and a Part A or B Medicare EOB to BCBSIL when filing a claim. |</p>
<table>
<thead>
<tr>
<th>Medical Claims Administrators</th>
<th>If UnitedHealthcare (UHC) is Your Medical Claims Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Reach a Service Associate</td>
<td>1-877-506-7221</td>
</tr>
<tr>
<td>Monday through Friday</td>
<td></td>
</tr>
<tr>
<td>HCN</td>
<td></td>
</tr>
<tr>
<td>To Reach a Service Associate</td>
<td>1-877-921-7222</td>
</tr>
<tr>
<td>Monday through Friday</td>
<td></td>
</tr>
<tr>
<td>PPO/Non-PPO</td>
<td></td>
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</tbody>
</table>
## MEDICAL CLAIMS ADMINISTRATORS

**IF UNITEDHEALTHCARE (UHC) IS YOUR MEDICAL CLAIMS ADMINISTRATOR**

<table>
<thead>
<tr>
<th>For Precertification (Care Coordination) Monday through Friday</th>
</tr>
</thead>
</table>
| Call the telephone number listed on your ID card if you are enrolled in the HCN and use non-network providers. If you are enrolled in the PPO/Non-PPO, you must contact UHC’s Care Coordination if you need hospitalization, surgery or other services as noted within the SPD. **If you don’t contact Care Coordination to precertify, a $250 penalty will be applied in some cases before you receive any reimbursement or in some cases the service may not be covered.**

**Precertification is not a determination of eligibility for benefits or participation in the Plan.**

A registered nurse will:

- Answer your questions and guide you through your particular situation.
- Precertify recommended hospitalizations, surgeries (inpatient and outpatient) and other services.
- Determine if the setting for treatment is appropriate.
- If you are enrolled in the PPO/Non-PPO option, you must contact Care Coordination if you need hospitalization, surgery, second opinions, Approved Home Care Agency care, Hospice Care, and Skilled Nursing Facilities.

You will need to provide information listed on your ID card, as well as information about the recommended surgery, hospitalization or service. The nurse may contact your physician to obtain additional information.

**Important:** When enrolled in the HCN and seeking care from a non-network provider or if you are enrolled in the PPO/Non-PPO, a substantial penalty will apply if you don’t call Care Coordination in advance or within the first 48 hours after an emergency hospital admission.

For information concerning the Plan’s procedures for precertification claims and appeals, refer to *Appendix D* on Page 122.
# How to File a Claim

If you use a network provider, the provider will file a claim for benefits on your behalf. If you use non-network providers, you may have to file a claim. Information concerning the Plan’s procedures for submitting and processing claims and appeals from denied claims can be found in Appendix D on Page 122.

Each time you file a claim after using a non-network provider or non-network service you will receive an EOB. On the bottom half of each EOB is a new claim form you can use to file your next claim.

If you use a network provider or network service you will not receive an EOB unless it is not a covered benefit.

You can get additional claim forms through:

- The UHC Internet site for SBC at [http://uhc.provider.com/sbc](http://uhc.provider.com/sbc)
- The SBC company employee benefits intranet site at [http://intranet.sbc.com/benefits](http://intranet.sbc.com/benefits) (for active employees who have access to the intranet)
- SBC’s secure Internet site at [http://access.sbc.com](http://access.sbc.com) (from home)
- The UHC Customer Service Center at the telephone number provided on your ID card

Note: You are not required to use a claim form; it is provided for your convenience. If you do not use a claim form, please make sure that your Social Security Number is provided on your bill. Mail your claim to the address on the back of your ID card.

If you choose to use a claim form, you must:

- Complete the Claim Transmittal form
- Mail the form and the medical bills to the address on the form.

*Remember to keep a copy for your records.*

## For Appeals

UnitedHealthcare  
Attention: Appeals  
P.O. Box 30557  
Salt Lake City, UT 84130-0557
<table>
<thead>
<tr>
<th>Internet Access and Choosing and Changing Your PCP</th>
<th>To review the provider listings and choose a network PCP, specialist, hospital or facility, access:</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
<td>Important: If you are selecting a new PCP, call the PCP’s office to verify the practice is accepting new patients before you finalize your decision.</td>
</tr>
<tr>
<td></td>
<td><strong>If you don’t select a PCP when you enroll, UHC will select one for you.</strong> Once enrolled, you can change your PCP at any time, any PCP changes will be effective immediately after you contact the Medical Claims Administrator and your selection has been processed, provided the PCP is accepting new patients. There are two ways to change your PCP:</td>
</tr>
<tr>
<td></td>
<td>1. Once you’ve enrolled through SBC Connect and UHC has received your enrollment, you can have online access to your personal medical and claim information. Here’s how:</td>
</tr>
<tr>
<td></td>
<td>§ Provide the member and group numbers printed on your ID card and choose a username and password.  <em>Note: Each of your covered dependents must register individually.</em></td>
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<tr>
<td></td>
<td>§ UHC provides an online service that gives you access to information about your health care benefits. To assure confidentiality of your personal data, you must register and be a current UHC member to use the service. Registered users may:</td>
</tr>
<tr>
<td></td>
<td>• Change your PCP online at any time</td>
</tr>
<tr>
<td></td>
<td>• Access personal benefit and claims information</td>
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<tr>
<td></td>
<td>• Replace a lost ID card</td>
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<td></td>
<td>• Create your own mailbox to receive medical information on topics of your choice</td>
</tr>
<tr>
<td></td>
<td>• Research specific health conditions</td>
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<tr>
<td></td>
<td>• Estimate costs for selected conditions</td>
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<td></td>
<td>• Compare hospitals based on personal preference</td>
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<td></td>
<td>2. Call UHC at 1-877-506-7221, and speak with a service associate.</td>
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</table>
**MEDICAL CLAIMS ADMINISTRATORS**

**IF UNITEDHEALTHCARE (UHC) IS YOUR MEDICAL CLAIMS ADMINISTRATOR**

<table>
<thead>
<tr>
<th><strong>Optum® NurseLine</strong> (Call the Telephone Number on Your ID Card)</th>
<th>Because your family’s illnesses and urgent care needs don’t always occur between the hours of 8 a.m. and 5 p.m. UHC offers you Optum® NurseLine or LIVE Nurse Chat – a staff of registered nurses ready to answer your questions on a variety of medical subjects 24 hours a day, 365 days a year. They can:</th>
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</thead>
<tbody>
<tr>
<td><strong>Optum® LIVE Nurse Chat</strong></td>
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</tbody>
</table>
| • Click the "Live Nurse Chat" link on myuhc.com  
• Provide a name for the nurse to use during your chat (this name or "screen name" as it’s sometimes referred can be your actual name or something else)  
• Enter your age and gender  
• Select "Continue" if you accept the Terms and Conditions to chat with a nurse  

*Live nurse chat sessions are securely operated, with access granted only to you and the nurse. Your chat will be personal and anonymous. If you have questions about your privacy, review the privacy policy before you start your session. In addition, feel free to ask the nurse about the privacy policy.* | • Help you determine whether you should schedule an appointment with your regular physician, or go to an emergency room or urgent care center  
• Answer your general health-related questions  
• Offer assistance in situations where first aid or home care is appropriate  
• Help you understand surgical procedures or diagnostic tests  
• Provide referral information  |
<p>| <strong>Healthy Pregnancy Program</strong> | In life-threatening situations, call 911 (if available), the local police or fire department, or go directly to the nearest hospital emergency room for treatment.  |
| UHC sponsors the Healthy Pregnancy Program to help you through your pregnancy. This program provides you with access to information about prenatal care and pregnancy. For example, you may receive written materials through this program to help you learn about the health risks that may be associated with pregnancy. Or, if your pregnancy is considered high risk, you may be referred to a Care Coordinator, who will coordinate the care and services you receive. There is no cost to participate in this voluntary program. Call the UHC Customer Service Center at the toll-free telephone number on your ID card for information about how to enroll. |</p>
<table>
<thead>
<tr>
<th><strong>MEDICAL CLAIMS ADMINISTRATORS</strong></th>
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<tbody>
<tr>
<td><strong>IF UNITEDHEALTHCARE (UHC) IS YOUR MEDICAL CLAIMS ADMINISTRATOR</strong></td>
</tr>
<tr>
<td><strong>UHC Medicare Crossover Program</strong></td>
</tr>
<tr>
<td><strong>Additional Savings Opportunity</strong></td>
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<table>
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<tr>
<th><strong>HMO CONTACT INFORMATION</strong></th>
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<tbody>
<tr>
<td><strong>SBC CONNECT (HEWITT ASSOCIATES)</strong></td>
</tr>
<tr>
<td><strong>To Reach a Service Associate Monday through Friday</strong></td>
</tr>
<tr>
<td><strong>Internet Access</strong></td>
</tr>
<tr>
<td><strong>For Appeals</strong></td>
</tr>
<tr>
<td>ENROLLMENT AND ELIGIBILITY VENDOR</td>
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<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>SBC CONNECT (HEWITT ASSOCIATES)</td>
</tr>
<tr>
<td>(ALSO RESPONSIBLE FOR ENROLLMENT AND ELIGIBILITY APPEALS)</td>
</tr>
</tbody>
</table>

**To Reach a Service Associate, the Interactive Voice Response System (IVR) or SBC Connect's Web Site**

Visit [http://resources.hewitt.com/sbc](http://resources.hewitt.com/sbc) or call SBC Connect at **1-877-722-0020** (domestic) or **+1-847-883-0866** (international) to enroll in your health care plans or to inquire about eligibility, cost of coverage, administration, COBRA, change in status events, billing and general information.

SBC Connect service associates are available Monday through Friday. SBC Connect's 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 Web site or IVR, or to speak to a service associate, you will need your SBC Connect password and Social Security Number.

If a claim for benefits is denied due to eligibility, the claim will be processed according to the procedures described in *Appendix D* on Page 122.

**For Appeals**

SBC Connect
Benefits Determination Review Team
P. O. Box 1407
Lincolnshire IL 60069-1407

**Full-Time Student Verification Process**

If your child is no longer a Full-time Student you **must contact SBC Connect** and notify a service associate that your child is no longer eligible for coverage. In addition, SBC Connect will solicit employees for student status verification once per year in August. It is a passive enrollment, so only participants whose dependent is no longer a student will be required to call. Verification will occur through the IVR or an SBC Connect service associate.
<table>
<thead>
<tr>
<th><strong>PRESCRIPTION DRUG CLAIMS ADMINISTRATOR</strong></th>
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<tbody>
<tr>
<td><strong>CAREMARK</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To Reach a Service Associate</strong>&lt;br&gt;Monday through Saturday</td>
<td><strong>1-800-378-8851</strong></td>
</tr>
<tr>
<td><strong>Retail Prescription Drug Program</strong>&lt;br&gt;(for short-term and immediate medications up to 30 days)</td>
<td><strong>How to File a Retail Claim</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Further information concerning the Plan’s procedures for submitting and processing claims and appeals from denied claims can be found in <em>Appendix D</em> on Page 122.</td>
<td></td>
</tr>
<tr>
<td><em>Active Employees (except employees covered by the collective bargaining agreement with IBEW 494)</em>: Pay 100% of the prescription and file a claim for reimbursement of 90% of Eligible Expenses.</td>
<td></td>
</tr>
<tr>
<td><em>Retirees and employees covered by the collective bargaining agreement with IBEW 494</em>: Present your card at the network retail pharmacy and pay 10% of Eligible Expenses and any applicable deductibles. The pharmacist will file a claim on your behalf.</td>
<td></td>
</tr>
<tr>
<td>Send your receipt and claim form to the address below. Claim forms are available through:</td>
<td></td>
</tr>
<tr>
<td>▪ The SBC company employee benefits intranet site at <a href="http://intranet.sbc.com/benefits/">http://intranet.sbc.com/benefits/</a> (for active employees who have access to the intranet)</td>
<td></td>
</tr>
<tr>
<td>▪ SBC’s secure Internet site at <a href="http://access.sbc.com">http://access.sbc.com</a> (from home)</td>
<td></td>
</tr>
<tr>
<td>▪ Caremark at <strong>1-800-378-8851</strong></td>
<td></td>
</tr>
<tr>
<td>Mail claims to:</td>
<td></td>
</tr>
<tr>
<td>Caremark&lt;br&gt;SBC Dedicated Unit&lt;br&gt;P.O. Box 686005&lt;br&gt;San Antonio, TX 78268-6005</td>
<td></td>
</tr>
<tr>
<td><em>Remember to keep a copy for your records.</em></td>
<td></td>
</tr>
</tbody>
</table>
### Mail Service Prescription Drug Program
(for long-term medications from 31 to 90 days)

**New Prescriptions**
For all new prescriptions, you must send in the *original* prescription with a Caremark Patient Profile/Order Form.

Enclose a check or money order for the Copayments/Coinsurance, *if applicable*, or write your credit card number, with expiration date, on the order form. Mail the order form to Caremark at:

Caremark  
P.O. Box 7616  
Mt. Prospect IL 60056-7616

*Employees covered by the collective bargaining agreement with IBEW 494 have a Copayment of $5 for each generic and $15 for each brand name medication. Refer to Page 76 for additional information.*

**Mail Service Refills**
You can request refills on maintenance medications by mail, phone or Internet. Order three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive from Caremark.

1. To Refill-by-Mail, attach the refill label provided with your prescription order to a Mail Service Patient Profile/Order Form.
2. Enclose a check or money order for the Copayments/Coinsurance, *if applicable*, or write your credit card number, with expiration date, on the order form. Mail the order form to Caremark in the pre-addressed envelope to:

Caremark  
P.O. Box 7616  
Mt. Prospect IL 60056-7616

*Employees represented by IBEW 494 have a Copayment of $5 for each generic and $15 for each brand name medication. Refer to Page 76 for additional information.*

- To order refills over the phone 24 hours a day, use a touch-tone phone to call toll-free at **1-800-378-8851**.
- To order refills through the Web site or check the status of your order, log on to [www.caremark.com](http://www.caremark.com) and choose the Online Pharmacy Service option.
<table>
<thead>
<tr>
<th>Prescription Drug Claims Administrator</th>
<th>Caremark</th>
</tr>
</thead>
<tbody>
<tr>
<td>For First Level Appeals</td>
<td>Caremark</td>
</tr>
<tr>
<td></td>
<td>Attn: Communications Unit/SBC Appeals</td>
</tr>
<tr>
<td></td>
<td>7034 Alamo Downs Parkway</td>
</tr>
<tr>
<td></td>
<td>San Antonio TX 78238</td>
</tr>
<tr>
<td>For Second Level Appeals</td>
<td>Caremark</td>
</tr>
<tr>
<td></td>
<td>Attn: Appeals Department</td>
</tr>
<tr>
<td></td>
<td>7034 Alamo Down Parkway</td>
</tr>
<tr>
<td></td>
<td>San Antonio TX 78238</td>
</tr>
</tbody>
</table>
Internet Access
www.caremark.com

RXrequest™

Use a touch-tone phone to call toll-free at 1-800-378-8851 or visit www.caremark.com, your online prescription service, to order prescription refills or inquire about the status of your order. Caremark’s fully automated refill phone service and www.caremark.com are available 24 hours a day. When you call or logon, be ready to provide:

- Participant’s Social Security Number or member ID
- Participant’s year of birth
- Your VISA, Discover, MasterCard or American Express number, with expiration date, if applicable*

*Employees represented by IBEW 494 have a Copayment of $5 for each generic and $15 for each brand name medication. Refer to Page 76 for additional information.

Personalized Options. Once registered on the site (group code*, Social Security Number or member ID, date of birth and a self selected password are required for initial registration), members will be able to view detailed information about personal prescription benefits and prescription information for minor dependents. Members will need their group code, social security number or member ID, and their password to successfully login each time they use the site.

*The group code is on the member’s ID card. The system will e-mail the group code on request should the member not have access to it.

Refill Request. Members can order mail service prescriptions from a list of ready-to-refill prescriptions for themselves and their covered minor dependents.

Order Status. Recent orders are displayed with drug names and prescription numbers. If an order ships using a method other than U.S. mail, a tracking number is provided that ties directly to the carrier’s Web site.

Prescription History. Members are able to view their prescription history for up to 13 months.

Drug Coverage. Determine whether or not a drug is covered, find payment information for mail and retail prescriptions, or view your benefits summary online.

Print Forms. Members are able to print both claim and mail order forms from this Web site.
### Mental Health and Substance Abuse (MH/SA) Claims Administrator

**ValueOptions**

<table>
<thead>
<tr>
<th>To Reach a Care Manager and for Precertification</th>
<th>1-800-554-6701</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are enrolled in the PPO/Non-PPO, you must contact <em>ValueOptions</em>. In order to receive MH/SA benefits under the Plan, you must call the MH/SA Claims Administrator and precertify outpatient and non-emergency MH/SA services. <strong>Without precertification, the Plan will not pay any benefits, even if you see a network provider.</strong></td>
<td></td>
</tr>
<tr>
<td>When you call the MH/SA Claims Administrator, a clinical care manager will assess your situation and provide you with a choice of at least two to three providers, if available. After you select a provider and make an appointment, you must again contact the MH/SA Claims Administrator so the provider you selected can be precertified. If you receive emergency hospital treatment and are admitted to the hospital for further treatment, you must call the MH/SA Claims Administrator within 48 hours after receipt of emergency services. If you do not notify the MH/SA Claims Administrator within 48 hours, the Plan will not pay any benefits.</td>
<td></td>
</tr>
<tr>
<td><strong>Precertification is not a determination of eligibility for benefits or participation in the Plan.</strong></td>
<td></td>
</tr>
<tr>
<td>Information concerning the Plan’s procedures for submitting and processing claims and appeals from denied claims can be found in <em>Appendix D</em> on Page 122.</td>
<td></td>
</tr>
</tbody>
</table>
**MENTAL HEALTH AND SUBSTANCE ABUSE (MH/SA) CLAIMS ADMINISTRATOR**

**VALUEOPTIONS**

| How to File a Claim | If you see a *ValueOptions* network provider, you will not need to submit any claims. Your provider will do that for you. If you see a non-network provider, you must file a claim form.  
  
  Information concerning the Plan’s procedures for submitting and processing claims and appeals from denied claims can be found in *Appendix D* on Page 122.  
  
  Claim forms are available through:  
  - The SBC company employee benefits intranet site at [http://intranet.sbc.com/benefits/](http://intranet.sbc.com/benefits/) (for active employees who have access to the intranet)  
  - SBC’s secure Internet site at [http://access.sbc.com](http://access.sbc.com) (from home)  
  - *ValueOptions* at 1-800-554-6701  
  
  Mail claims to:  
  
  *ValueOptions*  
  P.O. Box 140489  
  Irving, TX 75014  
  
  *Remember to keep a copy for your records.* |
| For Appeals | *ValueOptions*  
  P.O. Box 140489  
  Irving, TX 75014 |
<p>| Internet Access | <a href="http://www.valueoptions.com">http://www.valueoptions.com</a> |</p>
<table>
<thead>
<tr>
<th><strong>PENSION AND SERVICE BRIDGING ADMINISTRATOR</strong>&lt;br&gt;<strong>SBC PENSION AND SAVINGS PLAN SERVICE CENTER (MELLON HR SOLUTIONS)</strong>&lt;br&gt;</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To Reach a Service Associate</strong>&lt;br&gt;Monday through Friday</td>
<td>Contact the SBC Pension and Savings Plan Service Center toll-free at <strong>1-800-557-3640</strong> (domestic) or <strong>+1-201-363-2953</strong> (international). For TTY services for the hearing-impaired, call the SBC Pension and Savings Plan Service Center toll-free at <strong>1-800-833-8334</strong>.</td>
</tr>
<tr>
<td><strong>Report a Change of Address</strong> (applies to a retiree or someone who is considered LTD, COBRA or a surviving spouse/RDP and is inclusive of anyone not currently actively employed), <strong>Death or Inquire About Your Net Credited Service Date and/or The Bridging of Your Service and Mandatory Portability Agreement (MPA)</strong></td>
<td>You will need your SBC Pension and Savings Plan Service Center PIN and Social Security Number when you call.</td>
</tr>
<tr>
<td><strong>For Appeals</strong></td>
<td>SBC Pension and Savings Plan Service Center&lt;br&gt;P. O. Box 420&lt;br&gt;Little Falls, NJ 07424</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SBC BENEFIT INTERNET AND INTRANET ACCESS</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Active employees with access to the SBC intranet can access benefits information through the SBC company employee benefits intranet site at <a href="http://intranet.sbc.com/benefits/">http://intranet.sbc.com/benefits/</a>.</td>
<td></td>
</tr>
<tr>
<td>You can also get benefits information from home at any time at <a href="http://access.sbc.com">http://access.sbc.com</a> (SBC’s secure Internet site). Enter your Social Security Number as your username and your five-digit ZIP code as your password.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D: Filing A Claim

Preservice Claims (Precertification)
The Plan requires that you obtain precertification of certain services or they will not be covered or a substantial penalty will be applied against any payments that would otherwise be payable under the Plan.

Information identifying when precertification is required is provided in the sections describing the applicable benefits as well as information concerning when and how to initiate the precertification process.

If your request or claim for precertification (preservice claim) was submitted properly with all needed information, you will receive written notice of the decision from the applicable Claims Administrator within 15 days of receipt of the claim. The Claims Administrator may extend this period one time for up to 15 days, if it determines that special circumstances require more time to determine your claim. You will be notified within the initial 15-day period, if an extension is necessary and why.

If you filed the request improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 15 days after the request was received and may and may put your request on hold until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be denied.

Urgent Situations That Require Immediate Action
If you require emergency care, obtain the care and follow the applicable precertification provisions.

If you do not require immediate care but, in the opinion of a physician with knowledge of your medical condition, a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, your request will be considered an urgent care claim. In these situations:

- You will receive notice of the pre-approval determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.
You will be notified of a determination no later than 48 hours after:

- The Claims Administrator’s receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

**Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent claim as defined in the previous section, your request will be decided by the Claims Administrator within 24 hours of the receipt of your request for extended treatments, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request is not made at least 24 hours prior to the end of the approved treatment, it will be decided within the time period provided for a claim for urgent care, which is described in the previous section.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

If the Claims Administrator determines that coverage for a course of treatment that has been previously approved will be ended sooner than the period or number of treatments initially approved, the Claims Administrator will advise you of this decision in sufficient time to pursue an appeal of the change as described below.

**Filing a Claim for Benefits After Service Has Been Received (Post-Service Claims)**

All claims for benefits must be submitted no later than two years from the date of service. This time limit does not apply if you are legally incapacitated. Your medical provider may submit a claim on your behalf.

To submit a claim for payment or reimbursement of your Eligible Expenses under the Plan, you may use the claim form provided by the Claims Administrator but you are not required to, but you must provide the information specified on the form. If you use the form, fill out the form completely and attach a copy of the bill from your provider. In addition to information identifying yourself, your coverage and the recipient of the service, if different, the claim form includes:

- Authorization for the medical provider to release necessary information to the Claims Administrator to pay the medical provider directly for work performed for you and your eligible dependents
- Your signature certifying the accuracy of the information provided

If you need claim forms, access the SBC company employee benefits intranet site at [http://intranet.sbc.com/benefits/](http://intranet.sbc.com/benefits/) or SBC’s secure Internet site at [http://access.sbc.com](http://access.sbc.com) or the appropriate administrator/vendor. If you have any questions about a decision on your claim, contact the appropriate Claims Administrator. When discussing your claim, refer to the correspondence you have received from the Claims Administrator.

Once you or your provider has submitted a claim for payment or reimbursement, the Claims Administrator will notify you of its decision within 30 days of the date your claim is received. The
Claims Administrator may extend this period one time for up to 15 days if it determines that special circumstances require more time to determine your claim. You will be notified within the initial 30-day period if additional time is needed and what special circumstances require the extra time.

If the Claims Administrator needs additional information from you, you will have 45 days from the time of 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 of 30 or 45 days, whichever is applicable.

If Your Claim is Denied
You may treat your claim as denied if you receive a written or electronic notice from the Claims Administrator (oral if the claim is for urgent care) that denies your claim either in whole or in part.

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

- Specific reasons for the denial*
- Specific references to the Plan provision upon which the denial is based
- 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 statement that the determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit on coverage and that an explanation of the scientific basis and clinical judgment used to apply the terms of the plan to the medical circumstances will be provided free of charge upon request (if applicable).
- A description of any additional information to make your claim acceptable (if applicable) and the reason the information is needed
- A description of the procedure by which you may appeal the denial to the Plan’s named fiduciary
- A statement concerning your right to file a civil action under ERISA after the required reviews have been completed.

How to Appeal a Denied Claim
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 someone authorized by you must make the request within 180 days of receipt of the denial notice.

At any time, you may make inquiries concerning claims via letter or telephone. These inquiries are not considered formal appeals. It is not necessary to make an informal inquiry before filing an appeal.

A written request for review should be sent directly to the appropriate named fiduciary as provided in your denial letter or, if you received no denial letter, to the appropriate Claims Administrator.*
*If your claim has been denied on the basis of your eligibility to enroll or participate in the CHCP, you should follow the procedures provided in the “If You Want to Appeal a Claim Denied on the Basis of Ineligibility to Enroll or Participate in the CHCP” section on Page 127.

If you or your authorized representative sends a written request for review of a denied claim, you or your representative has 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
- 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
- If your claim was denied based on Medical Necessity or experimental treatment or similar exclusion or limit, request and receive free of charge, an explanation of the scientific basis or clinical judgment relied in making the decision on your claim.
- Reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Your request should also include:

- The patient's name and the identification number from the ID card
- The date(s) of medical service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any documentation or other written information to support your request for claim payment

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 Enrollment and Eligibility Vendor 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. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field that 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. You consent to this referral and the sharing of pertinent medical claim information.

The Claims Administrator’s decision will be in writing or sent electronically and will include:

- Specific reasons for the denial*
- Specific references to the Plan provision upon 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, or 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 that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.

If the determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit on coverage, a statement that an explanation of the scientific basis and clinical judgment used to apply the terms of the plan to the medical circumstances will be provided free of charge upon request.

A description of any additional information to make your claim acceptable (if applicable) and the reason the information is needed.

A description of the procedure by which you may request a second review of the denial to the Plan’s named fiduciary.

If the decision concerns a second level appeal, a statement concerning your right to file a civil action under ERISA.

*If your claim has been denied on the basis of your eligibility to enroll or participate in the CHCP, you should follow the procedures provided in the “If You Want to Appeal a Claim Denied on the Basis of Ineligibility to Enroll or Participate in the CHCP” section on Page 127.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial. The time period in which the Claims Administrator must decide your appeal for each type of claim is described in the following section.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator as the Claim Fiduciary. Your second level appeal request must be submitted to the Claims Administrator within 180 days from receipt of first level appeal decision. The process and information to be included in your second level appeal are the same as for the initial appeal. If your claim is denied upon the second review, you will receive a decision in writing, except for appeals of urgent care claims, and if the decision is a denial, the information that will be provided will include the items identified above.

For pre-service claims and post-service claims appeals, except determinations based on your eligibility to receive benefits under the CHCP, the applicable Claims Administrator has been delegated the exclusive right to interpret and administer the provisions of the Plan and the Claims Administrators decisions are conclusive and binding and not subject to further review by the named fiduciary. If the determination of your claim for benefits is based on your eligibility to receive benefits under the CHCP, the SBC Enrollment and Eligibility Appeals Committee (EEAC), has been delegated the exclusive right to interpret and administer the applicable provisions of the CHCP and the Committee’s decisions are conclusive and binding and not subject to further review by the named fiduciary. However, in either case, you may have further rights under ERISA, as provided in the section of this SPD that describes those rights.

Please note that the Claims Administrator’s decision is based only on whether or not benefits are available under the Plan for a particular treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.
Time Periods for Appeals Determinations

**Pre-Service and Post-Service Claim Appeals.** You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of **pre-service claims**, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of **post-service claims**, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, refer to the “Urgent Claim Appeals That Require Immediate Action” section below.

**Urgent Care Claim Appeals That Require Immediate Action.** Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition. The Claim’s Administrator’s response may be communicated orally, with a written confirmation within the following three days.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator’s decisions are conclusive and binding and not subject to further review by the named fiduciary. However, you may have further rights under ERISA, as provided in the section of this SPD that describes those rights.

**If You Want to Appeal a Claim Denied on the Basis of Eligibility to Enroll or to Participate in the CHCP**

If you have been denied reimbursement of Eligible Expenses on the basis of your eligibility to enroll or participate in the CHCP and you disagree with the decision, you may appeal the decision by filing a written request for review. You or someone authorized by you must make the request within 180 days of receipt of the denial notice.

At any time, you may make inquiries concerning your claim via letter or telephone. These inquiries are not considered formal appeals.

A written request for review should be sent directly to the Enrollment and Eligibility Vendor at:

SBC Connect
Benefits Determination Review Team
P. O. Box 1407
Lincolnshire IL 60069-1407
If you or your authorized representative sends a written request for review of a denied claim, you or your representative has 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 your appeal

- Request and examine, free of charge, documents that bear on your claim

In your appeal you should state as clearly and specifically as possible any facts and/or reasons why you believe the Enrollment and Eligibility Vendor’s action is incorrect. You should also include any new or additional evidence or materials in support of your appeal that you wish the Enrollment and Eligibility Vendor 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 on the basis of eligibility to enroll or participate in the CHCP will be appointed to decide the appeal.

A review and decision on your appeal will be made within 30 days after your appeal is received. If you do not receive notice of the decision by the end of the 30-day period, the appeal is considered denied.

The Enrollment and Eligibility Vendor’s decision will be in writing and will include the specific reasons and references to CHCP provides on which the decision is based.

If your claim is denied and you disagree with the decision, you may appeal the decision by filing a written request for a second review. You or someone authorized by you must make the request within 180 days of receipt of the denial notice.

A written request for review should be sent to the Enrollment and Eligibility Appeals Committee (EEAC) at:

- SBC Connect
  - Benefits Determination Review Team
  - P. O. Box 1407
  - Lincolnshire IL 60069-1407

If you or your authorized representative sends a written request for a second review of a claim denied on the basis of eligibility to enroll or participate in the CHCP, you maintain the rights described above concerning the ability to provide further information and review documents.

Qualified members of the EEAC who were not involved in the decision to deny your initial claim or to deny your first review on appeal will be appointed to decide the appeal.

A review and decision on your appeal will be made within 30 days after your appeal is received. If you do not receive notice of the decision by the end of the 30-day period, the appeal is considered denied.

The EEAC’s decision will be in writing and will include the specific reasons and references to Plan provisions on which the decision is based. The EEAC has full discretionary authority to interpret the provisions of the Plan and to determine eligibility for an entitlement to CHCP benefits.
If your appeal is denied, it is final and not subject to further review by the EEAC. However, you may have further rights under ERISA, as provided in the section of this SPD that describes those rights.
Important Benefits Information