

Summary of Material Modifications



IMPORTANT BENEFITS INFORMATION

Changes to AT&T Health and Welfare Plans for DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees covered by the IBEW Collective Bargaining Agreement

This is a Summary of Material Modifications (SMM) to the Summary Plan Descriptions (SPD) for the AT&T health and welfare plans listed in *Appendix A* of this SMM.

DISTRIBUTION: Distributed to all DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees covered by the collective bargaining agreement between DIRECTV LLC and IBEW System Council T-3, eff. Aug. 16, 2016 and the collective bargaining agreement between AT&T Services, Inc. and IBEW System Council T-3, eff. Aug. 20, 2016.

NIN: 78-38899

IMPORTANT INFORMATION

This Summary of Material Modifications (SMM) was written for easy readability, so, it may contain generalizations and informal terms rather than precise legal terms. Also, this SMM only summarizes benefits; individual situations may vary. In all cases, the official documents for the affected Plans (including component Programs) govern and are the final authority on the terms of the Plans. If there are discrepancies between the information in this SMM and the Plan, the Plan document will control. AT&T Inc. reserves the right to terminate or amend any and all of its employee benefit plans or programs at any time for any reason, including with respect to any "DIRECTV Bargained Employee" (as the term is defined below). Participation in the Plans is neither a contract nor a guarantee of future employment.

What Is This Document?

This is an SMM and describes a change in eligibility and in some cases benefits for the affected Plans. An SMM is legally required when material changes are made to the Plans.

What Action Do I Need to Take?

You should review this SMM and your Summary Plan Descriptions (SPDs) in their entirety, so you can understand the details of your benefits and take any required action. Keep this SMM with your SPDs and all other SMMs for future reference. They are your primary resource for questions about your benefits.

Why Did I Receive This Document?

You are receiving this SMM because the Plan's records indicate that you are a DIRECTV Bargained Employee (as the term is defined below) and are eligible to participate in the Programs listed in *Appendix A* effective Jan. 1, 2017.

Questions?

If you have questions about information in this SMM, your SPD or about the Programs, call the administrator listed in the "For More Information" section of this SMM.

Si usted tiene alguna dificultad en entender este documento, por favor póngase en contacto con el administrador que aparece en la sección que se titula "For More Information."

INTRODUCTION

This SMM is an update to the Summary Plan Descriptions (SPDs) for the AT&T health and welfare plans listed in *Appendix A* of this SMM. On July 24, 2015, AT&T Inc. (AT&T) purchased DIRECTV. Effective Jan. 1, 2017, DIRECTV Bargained Employees and their dependents will be eligible to participate in AT&T health and welfare benefit plans as described in this SMM. The DIRECTV Plan (as hereinafter defined) will no longer apply (except with respect to certain disability benefits).

For the purposes of this SMM:

1. "DIRECTV Bargained Employee" means a current employee who was employed by DIRECTV, who is now covered by the collective bargaining agreement between DIRECTV LLC and IBEW System Council T-3, eff. Aug. 16, 2016 and the collective bargaining agreement between AT&T Services, Inc. and IBEW System Council T-3, eff. Aug. 20, 2016 (collectively, CBA), and who will receive bargained-for benefits pursuant to the CBA on Jan. 1, 2017.
2. "DIRECTV Plan" means the DIRECTV Health and Welfare Benefit Plan.
3. "Eligible Former DIRECTV Bargained Employee" means a DIRECTV Bargained Employee who terminates employment during the term of the current CBA and who meets the applicable requirements to be eligible for post-retirement benefits.

NEW PARTICIPATING COMPANIES AND BARGAINING GROUPS

The Participating Companies and bargaining groups listed in *Appendix B* are added to the AT&T Plans and Programs listed in *Appendix A* effective Jan. 1, 2017.

ELIGIBILITY AND ENROLLMENT

All DIRECTV Bargained Employees are eligible for the Programs listed in *Appendix A* as of Jan. 1, 2017.

Eligibility for DIRECTV Employees and Dependents

All DIRECTV Bargained Employees and their dependents who are eligible to enroll in the DIRECTV Plan on Dec. 31, 2016, will be eligible to enroll in the Programs listed in *Appendix A (AT&T Programs)*, effective Jan. 1, 2017. Dependents who are enrolled in the DIRECTV Plan on Dec. 31, 2016 will not be required to complete the Dependent Eligibility Verification process described in the SPD as a condition of their 2017 enrollment in the AT&T Programs.

The following "Eligible Dependent Exceptions" provisions is added to the Midwest programs to allow to dependents of DIRECTV Bargained Employees under all AT&T Programs providing dependent coverage. In addition, domestic partners enrolled in the DIRECTV Plan on Dec. 31, 2016 will be eligible as a Legally Recognized Partner until Dec. 31, 2017, at which time the AT&T Legally Recognized Partner definition will apply. It is the intent of these provisions that dependents eligible for coverage and enrolled in the DIRECTV Plan will continue to be eligible under the AT&T Programs, through Plan Year 2017, provided the qualifying dependent relationship continues and subject to the maximum age limits under the applicable Programs. Eligibility will end for dependents of a DIRECTV Bargained Employee if the dependent relationship ends, for example upon divorce or the termination of a legal guardianship.

During 2017, all dependents of a DIRECTV Bargained Employee will be required to complete the Dependent Eligibility Verification process as provided in the applicable AT&T Program. The definition of Eligible Dependent in the applicable AT&T Program will apply, subject to the Eligible Dependent Exceptions. Dependents whose eligibility is not verified will lose coverage on Dec. 31, 2017.

Any dependents of a DIRECTV Bargained Employee added to coverage on or after Jan. 1, 2017 will be required to meet the definition of Eligible Dependent in the applicable AT&T Program without regard to this SMM and complete Dependent Eligibility Verification at the time of enrollment.

AT&T DENTAL PROGRAM (BARGAINED EMPLOYEES) AND AT&T ELIGIBLE FORMER EMPLOYEE DENTAL PROGRAM (ELIGIBLE FORMER BARGAINED EMPLOYEES)

DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees will be eligible to enroll under the terms of the following programs, as applicable: AT&T Dental Program (Bargained Employee) SPD – NIN 78-37958 and AT&T Eligible Former Employee Dental Program (Eligible Former Bargained Employees) SPD – NIN 78-37960. Effective Jan. 1, 2017, the following contribution rules apply to DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees, as applicable:

Automatic Enrollment for DIRECTV Bargained Employees

If a DIRECTV Bargained Employee does not take action during the AT&T enrollment period with respect to the AT&T Dental Program (Bargained Employees), they will automatically be enrolled, based on their current coverage level (e.g., individual to individual, etc.), into an AT&T Dental Program option based on the following rules:

DIRECTV Health and Welfare Plan Option	AT&T Dental Program
Aetna PPO	CIGNA PPO
Aetna DHMO (fully insured)	CIGNA DHMO (fully insured)
No coverage	No coverage

You can take action during Annual Enrollment and enroll and chose your coverage level (Individual, Individual +1, etc.).

Contribution Rules

Employee Classification		Contribution Rules
Regular and Term Employee (at least six months Term of Employment)	Full-time	You pay the following monthly contribution: Individual: \$7 Individual + 1: \$14 Individual + 2 or more: \$23
	Part-time (20 or more scheduled hours per week)	You pay 50% of the monthly Cost of Coverage.
	Part-time (less than 20 scheduled hours per week)	You pay 100% of the monthly Cost of Coverage.

Employee Classification		Contribution Rules
Eligible Former Employees	See the "Appendix C - Eligible Former Employees" section for Employee Classifications that may be eligible for the AT&T Eligible Former Employee Dental Program (Eligible Former Bargained Employees).	You pay 100% of the monthly Cost of Coverage. Eligible Former Employees who are Medicare Eligible are ineligible for coverage.
Calculation of the monthly Cost of Coverage is subject to adjustment from time to time at the Company's discretion.		

Waiver of Missing Tooth Exclusion

The AT&T Dental Program (Bargained Employees) exclusion for services associated with a tooth that was missing at the time of enrollment in the Program is hereby waived for DIRECTV Bargained Employees who enroll in coverage effective Jan. 1, 2017. This waiver will allow a DIRECTV Bargained Employee to obtain treatment for a missing tooth after enrollment.

AT&T DISABILITY INCOME PROGRAM

DIRECTV Bargained Employees will participate in the AT&T Disability Income Program and will have the same benefit provisions as AT&T Management Employees, except as provided below.

Eligibility – Short-Term Disability Benefits. DIRECTV Bargained Employees who are full-time, part-time or Term Employees are eligible for the short-term disability provisions under the AT&T Disability Income Program. Temporary Employees are not eligible.

Eligibility – Long-Term Disability Benefits. DIRECTV Bargained Employees who are full-time or part-time are eligible for the long-term disability provisions of the AT&T Disability Income Program. Temporary and Term Employees are not eligible.

Benefits. The AT&T Disability Income Program provides short-term, long-term and supplemental long-term disability benefits. Refer to the AT&T Disability Income Program SPD, NIN – 78-34908 for further information.

Employees Absent due to Disability. If you are absent from work due to a disability on Dec. 31, 2016, you will remain covered under the disability provisions of the DIRECTV Plan until you return to work. On and after Jan. 1, 2017, when you return to work, you will participate in the AT&T Disability Income Program.

A DIRECTV Bargained Employee who has met the eligibility waiting period and is enrolled in the DIRECTV disability policy on Dec. 31, 2016 will be eligible for the AT&T Disability Income Program on Jan. 1, 2017, without the need to complete the six (6) month waiting period under the AT&T Disability Income Program.

AT&T FLEXIBLE SPENDING ACCOUNT PROGRAM

DIRECTV Bargained Employees will participate in the AT&T Flexible Spending Account Plan and will have the contributions for health and welfare benefits, in which they have enrolled, deducted pre-tax, unless post-tax deductions are specifically elected. Participants may elect to contribute to an AT&T Health Care Spending Account, which requires a minimum contribution of \$100 and, effective Jan. 1, 2017, a maximum contribution of \$2,550. The provisions concerning Dependent Care Spending Account also apply to the DIRECTV Bargained Employees. The provisions in the AT&T Flexible Spending Account Plan related to payroll deduction contributions to a Health Savings Account are not applicable to DIRECTV Bargained Employees.

AT&T GROUP LIFE INSURANCE PROGRAM FOR ACTIVE EMPLOYEES

DIRECTV Bargained Employees will participate in the AT&T Group Life Insurance Program for Active Employees, and they will have the same benefit provisions as AT&T Management Employees, except as provided below.

Eligibility. DIRECTV Bargained Employees who are full-time, part-time or Term Employees are eligible for the group life provisions under the AT&T Group Life Insurance Program for Active Employees. Temporary Employees are not eligible.

Definition of Pay. The definition that applies to DIRECTV Bargained Employees is Pay Table 4.

DIRECTV Bargained Employees will also be eligible for the AT&T Dependent Group Life Insurance Program, the AT&T Special AD&D Insurance Program, and the AT&T Supplementary Group Life Insurance Program under the same rules that apply to the Midwest IBEW active bargained employees.

For further information on life insurance benefits for active employees, refer to the AT&T Group Life Insurance Program for Active Employees SPD - NIN 78-27162, which includes a description of the AT&T Dependent Group Life Insurance Program, the AT&T Special AD&D Insurance Program, and the AT&T Supplementary Group Life Insurance Program.

Eligible Former DIRECTV Bargained Employees. Eligible Former DIRECTV Bargained Employees will participate in the AT&T Eligible Former Employee Group Life Insurance Program for Bargained Employees, and they will have \$15,000 in Basic Life Insurance after Termination of Employment.

Eligible Former DIRECTV Bargained Employees will have Supplementary Life Insurance under the same rules that apply to eligible former Midwest IBEW bargained employees.

For further information, refer to the Eligible Former Employee Group Life Insurance Program for Bargained Employees SPD – NIN 78-27163.

Changes in The AT&T Life Insurance Programs

If a DIRECTV Bargained Employee takes no action during the AT&T enrollment period with respect to any supplementary life insurance coverage amount, the amount of coverage that the DIRECTV Bargained Employee had in force under the DIRECTV life policy on December 31, 2016 (rounded up to the next whole multiple of pay) will be the default election.

During the 2017 AT&T enrollment period, a DIRECTV Bargained Employee may accept the default level of coverage that will be shown on their Annual Enrollment materials or elect another amount for Child, Spouse/LRP or self as provided for under the AT&T Supplementary Group Life Insurance Program or AT&T Dependent Group Life Insurance Program. The AT&T default level of coverage is based on Pay and amounts will move from the DIRECTV schedule to the next highest level of coverage at AT&T.

A DIRECTV Bargained Employees will not be required to provide Evidence of Insurability for any supplementary life insurance amount elected during the AT&T enrollment period up to the amount that the DIRECTV Bargained Employee had in force under the DIRECTV life insurance policy on the December 31, 2016 (rounded up to the next whole multiple of pay), if that amount of coverage is otherwise permitted by the AT&T Supplementary Group Life Program. Increases in supplementary life insurance coverage for Self or your Spouse/LRP may require submission of Evidence of Insurability based on the terms of the AT&T Supplementary Group Life Insurance Program.

AT&T MIDWEST MEDICAL PROGRAM AND AT&T MIDWEST ELIGIBLE FORMER BARGAINED EMPLOYEE MEDICAL PROGRAM

DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees will be eligible to enroll under the terms of the following programs, collectively referred to as “Medical Programs,” with the modifications noted below.

- DIRECTV Bargained Employees: AT&T Midwest Medical Program (refer to SPD – NIN 78-35179 and its SMM – NIN 78-36211)
- Eligible Former DIRECTV Bargained Employees: AT&T Midwest Eligible Former Employee Medical Program (refer to SPD – NIN 78-35181 and its SMM 78-36211)

Automatic Enrollment for DIRECTV Bargained Employees

If a DIRECTV Bargained Employee, who is enrolled in the DIRECTV Plan as of Dec. 31, 2016, does not take action during the AT&T enrollment period with respect to the AT&T Midwest Medical Program, coverage for the Employee and Eligible Dependents will default, based on their current coverage level (e.g., individual to individual, etc.), to an AT&T Midwest Medical Program option based on the following rules:

DIRECTV Health and Welfare Plan Option	AT&T Medical Program
Choice	Option 1
Consumer	Option 2
Kaiser (fully insured)	Kaiser (fully insured), if offered in your area; if not then to the Option 2
Hawaii Medical Services Association (fully insured)	Hawaii Medical Services Association (fully insured)
No coverage	No coverage

You can take action during Annual Enrollment and enroll and chose your coverage level (Individual, Individual +1, etc.).

Contribution Rules

Employee Classification		Contribution Rules
Regular and Term Employee (less than 6 months Term of Employment)	Full-Time	You pay 100% of the monthly Cost of Coverage, until the first of the month in which you will achieve a Term of Employment of at least 90 days.
Regular and Term Employee (at least 90 days Term of Employment and less than 6 months Term of Employment)	Full-time	You pay the following monthly contribution Option 1 Individual: \$172 Family: \$704.95 Option 2 Individual: \$75 Family: \$545.36
Regular and Term Employee (at least six months Term of Employment)	Full-time	Hired, rehired or transferred on or before Aug. 15, 2016 You pay the following monthly contribution Jan. 1, 2017 through Dec. 31, 2017 Option 1 Individual: \$155 Family: \$335 Option 2 Individual: \$58 Family: \$138 Jan. 1, 2018 through Dec. 31, 2018 Option 1 Individual: \$169 Family: \$365 Option 2 Individual: \$79 Family: \$186 Jan. 1, 2019 through Dec. 31, 2019 Option 1 Individual: \$177 Family: \$382 Option 2 Individual: \$84 Family: \$196

Employee Classification		Contribution Rules
	Full-time	<p>Hired, rehired or transferred after Aug. 15, 2016 You pay the following monthly contribution</p> <p>Jan. 1, 2017 through Dec. 31, 2017 Option 1 Individual: \$172 Family: \$372 Option 2 Individual: \$75 Family: \$176</p> <p>Jan. 1, 2018 through Dec. 31, 2018 Option 1 Individual: \$174 Family: \$375 Option 2 Individual: \$83 Family: \$196</p> <p>Jan. 1, 2019 through Dec. 31, 2019 Option 1 Individual: \$177 Family: \$382 Option 2 Individual: \$84 Family: \$196</p>
	Part-time (25 or more scheduled hours per week)	Same as Full-Time based on date of hire, rehire or transfer
	Part-time (at least 17, but less than 25, or more scheduled hours per week)	You pay 50% of the monthly Cost of Coverage.
	Part-time (less than 17 scheduled hours per week)	You pay 100% of the monthly Cost of Coverage.
Eligible Former Employees	Full-time or Part-time at Termination of Employment	<p>You pay 100% of the monthly Cost of Coverage until you are eligible for Medicare.</p> <p>You are ineligible for coverage when you become eligible for Medicare.</p>
<i>Calculation of the monthly Cost of Coverage is subject to adjustment from time to time at the Company's discretion.</i>		

BENEFITS AT A GLANCE

DIRECTV Bargained Employees have four options available in which to enroll: two Health Care Network (HCN) options and two Preferred Provider Organization (PPO) options. The following tables summarize the benefits available to you.

Health Care Network Options:

The following tables apply to you.

Table 4 – Midwest IBEW - HCN Option 1 DTV

Deductible. This table has a separate Annual Deductible for each option (Network, ONA and Non-Network). Amounts incurred under one option do

not apply to the other option. Under family coverage, a covered person is eligible to receive benefits once the individual deductible amount is met.

The family deductible is met once a combination of a covered person's covered Allowable Expenses meets the Family Deductible amount. No one individual can contribute more than the Individual Deductible amount towards the Family Deductible.

Out of Pocket Maximum. Once an individual reaches the Individual Out-of-Pocket Maximum, the Program will begin to pay 100% of any Allowable Charges that individual incurs. Once payments for all family members reach the Family Out-of-Pocket Maximum, the Individual Out-of-Pocket Maximum for all family members will be considered met for the rest of the year and the Program will begin paying 100% of Allowable Charges that any family member incurs, unless you change Program options. The Network/ONA and Non-Network out-of-pocket maximums work in the same manner.

	Network	Non-Network	ONA	Limitations and Exceptions
Notification and Preauthorization Requirements				
Notification and Preauthorization Requirements	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	
Cost Sharing				
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	

Annual Deductible	Medical, including MH/SA For Individual and Family: 2017: \$500/\$1,000 2018: \$600/\$1,200 2019: \$700/\$1,400	Medical, including MH/SA For Individual and Family: 2017: \$1,300/\$2,600 2018: \$2,100/\$4,200 2019: \$2,450/\$4,900	Medical, including MH/SA For Individual and Family: 2017: \$500/\$1,000 2018: \$600/\$1,200 2019: \$700/\$1,400	Unless otherwise noted, the Annual Deductible applies.
Annual Out-of-Pocket Maximum	Medical, including MH/SA Includes Annual Deductible For Individual and Family: 2017: \$2,500/\$5,000 2018: \$3,000/\$6,000 2019: \$3,500/\$7,000	Medical, including MH/SA Includes Annual Deductible For Individual and Family: 2017: \$7,300/\$14,600 2018: \$9,000/\$18,000 2019: \$10,500/\$21,000	Medical, including MH/SA Includes Annual Deductible For Individual and Family: 2017: \$2,500/\$5,000 2018: \$3,000/\$6,000 2019: \$3,500/\$7,000	
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	

Preventive Care Services				
Preventive Care	0% Coinsurance	Not covered	0% Coinsurance	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.
Emergency Services				
Emergency Room (Emergency Medical Condition)	10% Coinsurance	10% Coinsurance	10% Coinsurance	
Ambulance Services (Emergency)	10% Coinsurance	10% Coinsurance	10% Coinsurance	
Non-Emergency Services				
Emergency Room (Non-Emergency)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Urgent Care Facility (Non-Emergency)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Ambulance Services (Non-Emergency)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Inpatient Services				
Facility Charge	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Room and Board	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Lab and X-Ray	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Physician and Surgeon Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	

Outpatient Services				
Office Visit				
Office Visit (Non-Specialist)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Office Visit (Specialist)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Outpatient Care				
Outpatient Surgery	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Outpatient Lab and X-Ray Services (excluding Preventive Care)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Outpatient Chemotherapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Mental Health and Substance Abuse Services				
Mental Health				
Mental Health Outpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Mental Health Inpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Substance Abuse				
Substance Abuse Outpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Substance Abuse Inpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	

Family Planning/Maternity Services				
Office Visit (Pre/Postnatal)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Hospital Delivery Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Infertility Services	Not covered	Not covered	Not covered	
Rehabilitation Services				
Physical Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Occupational Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Speech Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Cardiac Rehabilitation Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	Limited to 36 sessions per illness.
Additional Services				
Acupuncture	Not covered	Not covered	Not covered	
Chiropractic	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	Non-Network/ONA: Benefits for muscle manipulations and spinal adjustments are limited to \$200 per calendar year.

Durable Medical Equipment	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Home Health Care	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Hospice Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Organ and Tissue Transplant Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	10% Coinsurance	

Table 5 – Midwest IBEW HCN - Option 2 DTV

Deductible. This table has a separate Annual Deductible for each option (Network, ONA and Non-Network). Amounts incurred under one option do not apply to the other option.

If your coverage level is family, no individual can receive benefits until the Family Annual Deductible is met. The Family Deductible is met when one or a combination of covered person's covered Allowable Expenses meets the Family Deductible amount.

Out-of-Pocket Maximum. Once an individual reaches the Individual Out-of-Pocket Maximum, the Program will begin paying 100% of any Allowable Charges that person incurs. Once payments for all family members reach the Family Out-of-Pocket Maximum, the Individual Out-of-Pocket Maximum for all family members will be considered met for the rest of the year and the Program will begin paying 100% of Allowable Charges that any family member incurs, unless you change Program options. The Network/ONA and Non-Network out-of-pocket maximums work in the same manner.

	Network	Non-Network	ONA	Limitations and Exceptions
Notification and Preauthorization Requirements				
Notification and Preauthorization Requirements	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	

Cost Sharing				
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	
Annual Deductible	Medical, including Rx and MH/SA For Individual/Family: 2017: \$1,300/\$2,600 2018: \$1,300/\$2,600 2019: \$1,500/\$3,000	Medical, including Rx and MH/SA For Individual/Family: 2017: \$3,900/\$7,800 2018: \$3,900/\$7,800 2019: \$6,000/\$12,000	Medical, including Rx and MH/SA For Individual/Family: 2017: \$1,300/\$2,600 2018: \$1,300/\$2,600 2019: \$1,500/\$3,000	Unless otherwise noted, the Annual Deductible applies.
Annual Out-of-Pocket Maximum	Medical, including Rx and MH/SA Includes Annual Deductible For Individual/Family: 2017: \$6,450/\$12,900 2018: \$6,450/\$12,900 2019: \$6,550/\$13,100 Family deductible per individual capped at individual deductible Additional limits may apply	Medical, including Rx and MH/SA Includes Annual Deductible For Individual/Family: 2017: \$19,350/\$38,700 2018: \$19,350/\$38,700 2019: \$19,650/\$39,300	Medical, including Rx and MH/SA Includes Annual Deductible For Individual/Family: 2017: 6,450/\$12,900 2018: \$6,450/\$12,900 2019: \$6,550/\$13,100 Family deductible per individual capped at individual deductible Additional limits may apply	

Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	
Preventive Care Services				
Preventive Care	0% Coinsurance	Not covered	0% Coinsurance	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.
Emergency Services				
Emergency Room (Emergency Medical Condition)	20% Coinsurance	20% Coinsurance	20% Coinsurance	
Ambulance Services (Emergency)	20% Coinsurance	20% Coinsurance	20% Coinsurance	
Non-Emergency Services				
Emergency Room (Non-Emergency)	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Urgent Care Facility (Non-Emergency)	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Ambulance Services (Non-Emergency)	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Inpatient Services				
Facility Charge	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Room and Board	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Lab and X-Ray	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Physician and Surgeon Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	

Outpatient Services				
Office Visit				
Office Visit (Non-Specialist)	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Office Visit (Specialist)	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Outpatient Care				
Outpatient Surgery	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Outpatient Lab and X-Ray Services (excluding Preventive Care)	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Outpatient Chemotherapy	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Mental Health and Substance Abuse Services				
Mental Health				
Mental Health Outpatient Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Mental Health Inpatient Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Substance Abuse				
Substance Abuse Outpatient Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Substance Abuse Inpatient Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Family Planning/Maternity Services				
Office Visit (Pre/Postnatal)	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Hospital Delivery Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Infertility Services	Not covered	Not covered	Not covered	
Rehabilitation Services				
Physical Therapy	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Occupational Therapy	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Speech Therapy	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Cardiac Rehabilitation Therapy	20% Coinsurance	60% Coinsurance	20% Coinsurance	Limited to 36 sessions per illness.
Additional Services				
Acupuncture	Not covered	Not covered	Not covered	

Chiropractic	20% Coinsurance	60% Coinsurance	20% Coinsurance	Non-Network/ONA: Benefits for muscle manipulations and spinal adjustments are limited to \$200 per calendar year.
Durable Medical Equipment	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Home Health Care	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Hospice Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Organ and Tissue Transplant Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	20% Coinsurance	60% Coinsurance	20% Coinsurance	

Preferred Provider Organization Options:

The following tables apply to you:

Table 4 – Midwest IBEW PPO - Option 1 DTV

Deductible. This table has a separate Annual Deductible for each option (Network and Non-Network). Amounts incurred under one option do not apply to the other option. With family coverage, a covered person is eligible to receive benefits once the individual deductible amount is met.

The family deductible is met when a combination of covered person's covered Allowable Expenses meet the Family Deductible amount. No one individual can contribute more than the Individual Deductible amount towards the Family Deductible.

Out of Pocket Maximum. Once an individual reaches the Individual Out-of-Pocket Maximum, the Program will begin to pay 100% of any Allowable Charges that person incurs. Once payments for all family members reach the Family Out-of-Pocket Maximum, the Individual Out-of-Pocket Maximum for all family members will be considered met for the rest of the year, and the Program will begin paying 100% of Allowable Charges that any family member incurs, unless you change Program options. The Network and Non-Network out-of-pocket maximums work in the same manner.

	Network	Non-Network	Limitations and Exceptions
Notification and Preauthorization Requirements			
Notification and Preauthorization Requirements	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	
Cost Sharing			
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	
Annual Deductible	Medical, including MH/SA For Individual and Family: 2017: \$500/\$1,000 2018: \$600/\$1,200 2019: \$700/\$1,400	Medical, including MH/SA For Individual and Family: 2017: \$1,300/\$2,600 2018: \$2,100/\$4,200 2019: \$2,450/\$4,900	Unless otherwise noted, the Annual Deductible applies.
Annual Out-of-Pocket Maximum	Medical, including MH/SA Includes Annual Deductible For Individual and Family: 2017: \$2,500/\$5,000 2018: \$3,000/\$6,000 2019: \$3,500/\$7,000	Medical, including MH/SA Includes Annual Deductible For Individual and Family: 2017: \$7,300/\$14,600 2018: \$9,000/\$18,000 2019: \$10,500/\$21,000	
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	
Preventive Care Services			
Preventive Care	0% Coinsurance	Not covered	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.

Emergency Services			
Emergency Room (Emergency Medical Condition)	10% Coinsurance	10% Coinsurance	
Ambulance Services (Emergency)	10% Coinsurance	10% Coinsurance	
Non-Emergency Services			
Emergency Room (Non-Emergency)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Urgent Care Facility (Non-Emergency)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Ambulance Services (Non-Emergency)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Inpatient Services			
Facility Charge	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Room and Board	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Lab and X-Ray	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Physician and Surgeon Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Outpatient Services			
Office Visit			
Office Visit (Non-Specialist)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Office Visit (Specialist)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Outpatient Care			
Outpatient Surgery	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Outpatient Lab and X- Ray Services (excluding Preventive Care)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Outpatient Chemotherapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	

Mental Health and Substance Abuse Services			
Mental Health			
Mental Health Outpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Mental Health Inpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Substance Abuse			
Substance Abuse Outpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Substance Abuse Inpatient Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Family Planning/Maternity Services			
Office Visit (Pre/Postnatal)	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Hospital Delivery Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Infertility Services	Not covered	Not covered	
Rehabilitation Services			
Physical Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Occupational Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Speech Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Cardiac Rehabilitation Therapy	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	Limited to 36 sessions per illness.
Additional Services			
Acupuncture	Not covered	Not covered	
Chiropractic	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	Benefits for muscle manipulations and spinal adjustments are limited to \$200 per calendar year.

Durable Medical Equipment	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Home Health Care	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Hospice Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Organ and Tissue Transplant Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	10% Coinsurance	2017: 40% Coinsurance 2018: 50% Coinsurance 2019: 50% Coinsurance	

Table 5 – Midwest IBEW – PPO - Option 2 DTV

Deductible. This table has a separate Annual Deductible for each option (Network and Non-Network). Amounts incurred under one option do not apply to the other option.

If your coverage level is family, no individual can receive benefits until the Family Annual Deductible is met. The Family Deductible is met when one or a combination of covered person's covered Allowable Expenses meets the Family Deductible amount.

Out-of-Pocket Maximum. Once an individual reaches the Individual Out-of-Pocket Maximum, the Program will begin paying 100% of any Allowable Charges that person incurs. Once payments for all family members reach the Family Out-of-Pocket Maximum, the Individual Out-of-Pocket Maximum for all family members will be considered met for the rest of the year and the Program will begin paying 100% of Allowable Charges that any family member incurs, unless you change Program options. The Network and Non-Network out-of-pocket maximums work in the same manner.

	Network	Non-Network	Limitations and Exceptions
Notification and Preauthorization Requirements			
Notification and Preauthorization Requirements	See the "Notification and Preauthorization Requirements" section for more information.	See the "Notification and Preauthorization Requirements" section for more information.	

Cost Sharing			
Cost Sharing	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	You and the Program share in the Cost of Coverage. See the information in this table and the "Cost Sharing" section of the SPD for more information.	
Annual Deductible	Medical, including Rx and MH/SA For Individual/Family: 2017: \$1,300/\$2,600 2018: \$1,300/\$2,600 2019: \$1,500/\$3,000	Medical, including Rx and MH/SA For Individual/Family: 2017: \$3,900/\$7,800 2018: \$3,900/\$7,800 2019: \$6,000/\$12,000	Unless otherwise noted, the Annual Deductible applies.
Annual Out-of-Pocket Maximum	Medical, including Rx and MH/SA Includes Annual Deductible For Individual/Family: 2017: \$6,450/\$12,900 2018: \$6,450/\$12,900 2019: \$6,550/\$13,100 Family deductible per individual capped at individual deductible Additional limits may apply	Medical, including Rx and MH/SA Includes Annual Deductible For Individual/Family: 2017: \$19,350/\$38,700 2018: \$19,350/\$38,700 2019: \$19,650/\$39,300	
Coinsurance	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	Percent of the Allowable Charge you pay after the Annual Deductible. Coinsurance information is provided in this table for each Covered Health Service category. Additional information is also provided in the "Cost Sharing" section of the SPD.	

Preventive Care Services			
Preventive Care	0% Coinsurance	Not covered	Annual Deductible does not apply. See the "What Is Covered" section for information about Preventive Care Services.
Emergency Services			
Emergency Room (Emergency Medical Condition)	20% Coinsurance	20% Coinsurance	
Ambulance Services (Emergency)	20% Coinsurance	20% Coinsurance	
Non-Emergency Services			
Emergency Room (Non-Emergency)	20% Coinsurance	60% Coinsurance	
Urgent Care Facility (Non-Emergency)	20% Coinsurance	60% Coinsurance	
Ambulance Services (Non-Emergency)	20% Coinsurance	60% Coinsurance	
Inpatient Services			
Facility Charge	20% Coinsurance	60% Coinsurance	
Room and Board	20% Coinsurance	60% Coinsurance	
Lab and X-Ray	20% Coinsurance	60% Coinsurance	
Physician and Surgeon Services	20% Coinsurance	60% Coinsurance	
Outpatient Services			
Office Visit			
Office Visit (Non-Specialist)	20% Coinsurance	60% Coinsurance	
Office Visit (Specialist)	20% Coinsurance	60% Coinsurance	
Outpatient Care			
Outpatient Surgery	20% Coinsurance	60% Coinsurance	
Outpatient Lab and X-Ray Services (excluding Preventive Care)	20% Coinsurance	60% Coinsurance	
Outpatient Chemotherapy	20% Coinsurance	60% Coinsurance	

Mental Health and Substance Abuse Services			
Mental Health			
Mental Health Outpatient Services	20% Coinsurance	60% Coinsurance	
Mental Health Inpatient Services	20% Coinsurance	60% Coinsurance	
Substance Abuse			
Substance Abuse Outpatient Services	20% Coinsurance	60% Coinsurance	
Substance Abuse Inpatient Services	20% Coinsurance	60% Coinsurance	
Family Planning/Maternity Services			
Office Visit (Pre/Postnatal)	20% Coinsurance	60% Coinsurance	
Hospital Delivery Services	20% Coinsurance	60% Coinsurance	
Infertility Services	Not covered	Not covered	
Rehabilitation Services			
Physical Therapy	20% Coinsurance	60% Coinsurance	
Occupational Therapy	20% Coinsurance	60% Coinsurance	
Speech Therapy	20% Coinsurance	60% Coinsurance	
Cardiac Rehabilitation Therapy	20% Coinsurance	60% Coinsurance	Limited to 36 sessions per illness.
Additional Services			
Acupuncture	Not covered	Not covered	
Chiropractic	20% Coinsurance	60% Coinsurance	Benefits for muscle manipulations and spinal adjustments are limited to \$200 per calendar year.
Durable Medical Equipment	20% Coinsurance	60% Coinsurance	
Home Health Care	20% Coinsurance	60% Coinsurance	
Hospice Services	20% Coinsurance	60% Coinsurance	

Organ and Tissue Transplant Services	20% Coinsurance	60% Coinsurance	
Skilled Nursing Facility Services/Inpatient Rehabilitation Facility Services/Extended Care Facility Services	20% Coinsurance	60% Coinsurance	

Prescription Drugs

The following provisions of the Medical Programs, as described in your SPD, apply to DIRECTV Bargained Employees:

- Mandatory mail order for maintenance prescriptions after second fill at retail.
- Specialty pharmacy program.
- Personal Choice drugs are 100% paid by you.
- Mandatory Generics.
- Compound Medication limitation.
- Advanced Control Specialty pharmacy.
- New standard prescription drug formulary.
- Generic Step Therapy.

BENEFITS AT A GLANCE

If you are a DIRECTV Bargained Employee and you are enrolled in the Company Self-Funded program Option 1, see Table 4.

If you are a DIRECTV Bargained Employee and you are enrolled in the Company Self-Funded program Option 2, see Table 5.

Table 4 – DTV IBEW - Option 1

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Cost and Coverage			
Annual Deductible	Not applicable	Not applicable	Not applicable
Annual Out-of-Pocket Maximum	<p>Individual and Family: \$1,200/\$2,400</p> <ul style="list-style-type: none"> • Combined with Mail Order Prescription Drug Service. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. <p>Expenses that do not apply to the Annual Out-of-Pocket Maximum</p> <ul style="list-style-type: none"> • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic Drug penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy. 	Not applicable	<p>Individual and Family: \$1,200/\$2,400</p> <ul style="list-style-type: none"> • Combined with Network Retail Pharmacy. • Network Co-payments apply. • The Prescription Drug Annual Out-of-Pocket Maximum is separate from any medical and MH/SA Annual Out-of-Pocket Maximum that may apply. <p>Expenses that do not apply to the Annual Out-of-Pocket Maximum</p> <ul style="list-style-type: none"> • Prescription Drugs that are not a Covered Health Service. • Additional costs incurred for failure to comply with Program terms (such as mandatory Generic Drug penalty). • Prescriptions purchased at a Non-Network Retail Pharmacy.
Supply Limit	Up to a 30-day supply; limited to two (2) fills for maintenance prescriptions, then must use Mail Order. Subject to the Advanced Control Specialty Formulary provisions	Up to a 30-day supply	Up to a 90-day supply; subject to the Advanced Control Specialty Pharmacy
Generic Drug	\$10 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	\$20 Co-payment per prescription

Preferred Brand Drug	\$35 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	\$70 Co-payment per prescription
Non-Preferred Brand Drug	Co-payment per prescription 2017: \$60 2018: \$60 2019: \$70	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	Co-payment per prescription 2017: \$120 2018: \$120 2019: \$140
Co-payment Exceptions	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.
Other Requirements			
Mandatory Generic/Brand Restriction	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.
Mandatory Mail	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.
Rx Clinical Programs	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.

Specialty Pharmacy	<p>Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail.</p> <p>See the "Specialty Prescription Drug Services" section for Co-payment information.</p>	<p>Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail.</p> <p>See the "Specialty Prescription Drug Services" section for information.</p>	<p>Specialty Prescription Drugs are automatically processed through the Specialty Pharmacy when you use the Prescription Drug Benefits Administrator's Mail Order Prescription Drug Service.</p> <p>See the "Specialty Prescription Drug Services" section for Co-payment information.</p>
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Table 5 – DTV IBEW - Option 2

	Network Retail Pharmacy	Non-Network Retail Pharmacy	Mail Order
Cost and Coverage			
Annual Deductible	<p>Combined with Network medical, including MH/SA and CarePlus.</p> <p>See the <i>Benefits at a Glance</i> table of the "Medical and Mental Health/Substance Abuse Coverage" section for amounts. Annual Deductible applies before Co-payments apply.</p>	<p>Combined with Medical, including MH/SA and CarePlus.</p> <p>See the <i>Benefits at a Glance</i> table of the "Medical and Mental Health/Substance Abuse Coverage" section for amounts. Annual Deductible applies before Co-payments apply.</p>	<p>Combined with Network medical, including MH/SA and CarePlus.</p> <p>See the <i>Benefits at a Glance</i> table of the "Medical and Mental Health/Substance Abuse Coverage" section for amounts. Annual Deductible applies before Co-payments apply.</p>
Annual Out-of-Pocket Maximum	<p>Combined with Network medical, including MH/SA and CarePlus.</p> <p>See the <i>Benefits at a Glance</i> table of the "Medical and Mental Health/Substance Abuse Coverage" section for amounts.</p>	<p>Combined with Medical, including MH/SA and CarePlus.</p> <p>See the <i>Benefits at a Glance</i> table of the "Medical and Mental Health/Substance Abuse Coverage" section for amounts.</p>	<p>Combined with Network medical, including MH/SA and CarePlus.</p> <p>See the <i>Benefits at a Glance</i> table of the "Medical and Mental Health/Substance Abuse Coverage" section for amounts.</p>
Supply Limit	<p>Up to a 30-day supply; limited to two (2) retail fills for maintenance prescriptions; subject to the Advance Control Specialty Pharmacy</p>	<p>Up to a 30-day supply</p>	<p>Up to a 90-day supply; subject to the Advanced Control Specialty Pharmacy</p>
Generic Drug	<p>\$9 Co-payment per prescription</p>	<p>You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug.</p> <p>See the "Classification of Prescription Drugs" section.</p>	<p>\$18 Co-payment per prescription</p>

Preferred Brand Drug	\$35 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	\$70 Co-payment per prescription
Non-Preferred Brand Drug	\$70 Co-payment per prescription	You pay the greater of the applicable Network retail Co-payment, or the balance after the Program pays 75% of the Network Retail Cost of the Prescription Drug. See the "Classification of Prescription Drugs" section.	\$140 Co-payment per prescription
Co-payment Exceptions	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.	If the cost of the prescription is less than the applicable Co-payment, you pay the cost of the prescription rather than the Co-payment.
Other Requirements			
Mandatory Generic/Brand Restriction	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.	Applies. See the "Brand-Name Drugs Purchased When a Generic Drug Is Available" section.
Mandatory Mail	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.	Applies to purchase of Maintenance Prescription Drugs after second Fill at retail.
Rx Clinical Programs	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.	Medication Management Programs apply to promote safety and limit possible fraud, waste and abuse of Prescription Drugs. Preauthorization may be required in some cases.
Specialty Pharmacy	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail. See the "Specialty Prescription Drug Services" section for Co-payment information.	Specialty Prescription Drugs must be filled through the Prescription Drug Benefits Administrator's Specialty Pharmacy after the first Fill at retail. See the "Specialty Prescription Drug Services" section for information.	Specialty Prescription Drugs are automatically processed through the Specialty Pharmacy when you use the Prescription Drug Benefits Administrator's Mail Order Prescription Drug Service. See the "Specialty Prescription Drug Services" section for Co-payment information.

Health and Wellness Programs

DIRECTV Bargained Employees will be eligible to participate in the Health and Wellness provisions of the Medical Programs.

Transition of Care From the DIRECTV Plan

Medical. Any individual who has a serious health condition or is being treated on an intermediate care basis with continuing treatment needed after Dec. 31, 2016, should contact the appropriate AT&T Midwest Medical Program Benefits Administrator within 30 days of enrollment to arrange for Transition of Care services. Also, if a participant is hospitalized on Dec. 31, 2016, contact your AT&T Midwest Medical Program Benefits Administrator for assistance in arranging Transition of Care. See the "Contact Information" section of the AT&T Midwest Medical Program SPD for contact information.

Mental Health and Substance Abuse. If a participant is receiving services on an Outpatient Care basis and the provider is not covered under the AT&T Midwest Medical Program, the participant may request a transition benefit, which would allow the participant to keep the current Mental Health and Substance Abuse treatment provider for up to 90 days after Jan. 1, 2017 with a Network level benefit. After 90 days, the participant may continue using their current provider but will be covered at the Non-Network level.

Prescription Drugs. Any maintenance prescriptions must be transitioned to your new Benefits Administrator's mail order pharmacy since 90 day prescriptions are required. Contact Information can be found in the "Contact Information" section of your AT&T Midwest Medical Program SPD.

AT&T VISION PROGRAM (BARGAINED EMPLOYEES) AND AT&T ELIGIBLE FORMER EMPLOYEE VISION PROGRAM

DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees will be eligible to enroll under the terms of the following programs, as applicable: AT&T Vision Program (Bargained Employee) SPD – NIN 78-37955 or AT&T Eligible Former Employee Vision Program SPD – NIN 78-37956. The following contribution rules apply to DIRECTV Bargained Employees and Eligible Former DIRECTV Bargained Employees, as applicable, effective Jan. 1, 2017:

Automatic Enrollment for DIRECTV Bargained Employees

If a DIRECTV Bargained Employee does not take action during the AT&T enrollment period with respect to the AT&T Vision Program (Bargained Employees) they default, based on their current coverage level (e.g., individual to individual, etc.), to an AT&T Vision Program option based on the following rules:

DIRECTV Health and Welfare Plan Option	AT&T Vision Program
Vision	Vision
No coverage	No coverage

You can take action during Annual Enrollment and enroll and chose your coverage level (Individual, Individual +1, etc.).

Contribution Rules

Employee Classification		Contribution Rules
Regular and Term Employee (at least six months Term of Employment)	Full-time	You pay the following monthly contribution: Individual: \$2.00 Individual + 1: \$5.00 Family: \$8.00
	Part-time (20 or more scheduled hours per week)	You pay 50% of the monthly Cost of Coverage.
	Part-time (less than 20 scheduled hours per week)	You pay 100% of the monthly Cost of Coverage.
Eligible Former Employees	See the "Appendix C - Eligible Former Employees" section for Employee Classifications that may be eligible for the AT&T Eligible Former Employee Vision Program.	You pay 100% of the monthly Cost of Coverage. Eligible Former Employees who are Medicare Eligible are ineligible for coverage
<i>Calculation of the monthly Cost of Coverage is subject to adjustment from time to time at the Company's discretion.</i>		

FOR MORE INFORMATION

If you have any questions regarding the information provided in this SMM, contact the AT&T Benefits Center.

Who	How to Contact
AT&T Benefits Center Eligibility and Enrollment Vendor	877-722-0020 (domestic) 1-847-883-0866 (international) Customer service representatives are available Monday through Friday, 7 a.m. to 7 p.m. Central time. resources.hewitt.com/att

APPENDIX A

This appendix lists the affected Plans (including component Programs) and Policies to which this SMM applies.

AT&T Umbrella Benefit Plan No. 1

Medical Programs

AT&T Midwest Eligible Former Bargained Employee Medical Program

Dental Programs

AT&T Eligible Former Employee Dental Program (Eligible Former Bargained Employees)

Life Insurance Programs

AT&T Eligible Former Bargained Employee Group Life Insurance Program

Other Programs

AT&T Eligible Former Employee CarePlus – A Supplemental Benefit Program

AT&T Umbrella Benefit Plan No. 2

Employee Assistance Programs

AT&T Employee Assistance Program

Life Insurance Programs

AT&T Dependent Group Life Insurance Program

AT&T Special AD&D Insurance Program

AT&T Supplementary Group Life Insurance Program

International Business Travel – Supplemental Medical

AT&T International Business Travel – Supplemental Medical Program

AT&T Umbrella Benefit Plan No. 3

Medical Programs

AT&T Midwest Medical Program

Dental Programs

AT&T Dental Program (Bargained Employees)

Vision Programs

AT&T Vision Program (Bargained Employees)

AT&T Eligible Former Employee Vision Program

Life Insurance Programs

AT&T Group Life Insurance Program for Active Employees

Disability Programs

AT&T Disability Income Program

Other Programs

AT&T CarePlus – A Supplemental Benefit Program

Flexible Spending Account Plan

AT&T Flexible Spending Account Plan

Adoption Reimbursement Benefits

AT&T Adoption Reimbursement Policy

Commuter Benefits

AT&T Commuter Benefit Policy

APPENDIX B

This appendix lists the affected Participating Company and Bargaining Units that are added to the Programs listed in *Appendix A*.

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
GT - IBEW Local 55	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 89	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 111	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 206	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 291	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 291 - CC	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Call Center Employees Agreement)
GT - IBEW Local 354	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 426	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 449	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 714	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)

Population Abbreviation	Participating Company Name and Acronym	Employee Group	Bargaining Unit
GT - IBEW Local 768 - CC	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Call Center Employees Agreement))
GT - IBEW Local 769	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 827	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 949	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 1186	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 1250	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 1426	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)
GT - IBEW Local 1597	DIRECTV, LLC GT	Bargained	IBEW System Council T-3 (AT&T Midwest Contract) (Out-of-Region Technicians Agreement)