crowns, bridge work or dentures, or re-lining of dentures.

• Orthodontics: Services for the prevention and correction of malocclusion of teeth (crooked teeth).

- Effective Jan. 1, 1993, the maximum lifetime benefit payable for orthodontia is $1,100 for each covered person age 20 or over, or $1,452 for each covered person under age 20. This maximum is in addition to and separate and distinct from the plan's $1,210 per calendar-year maximum for regular dental benefits.
- If you are under age 20 and you reached the $1,320 maximum lifetime benefit payable for orthodontia prior to Jan. 1, 1993, you will be eligible for the increased maximum lifetime benefit only if you are still receiving active orthodontic treatment. The bands must still be in place.

• Oral splints for non-surgical treatment of temporomandibular joint dysfunction (TMJ).

- Effective Jan. 1, 1993, the annual benefit maximum for oral splints for each covered participant is $250 with a lifetime maximum of $1,000.

• General anesthesia, when medically necessary and administered in connection with oral surgery. However, anesthesia agents and local anesthesia are not covered expenses.

• Sealant coverage: one treatment per lifetime for participants age 13 and under. Benefits are limited to one application per tooth or per quadrant during the lifetime of the patient.

regarding materials to be used, such as choosing between precious metals and plastic for restorations.

If you and the dentist decide on the more costly treatment, you are responsible for charges beyond those for the less costly alternate treatment paid by Provident.

Provident will pay the lower schedule amount, provided the treatment meets acceptable dental standards. Whenever the alternate procedures provision is applied, Provident's dental consultant reviews the claim.

Predetermination of Benefits

Predetermination of benefits lets you know what services are covered and what payments may be made for treatment before the work is done.

If you or one of your covered family members expects to have dental expenses of more than $200, such as expenses for dentures or crowns or root canal therapy, you should ask your dentist to file for predetermination of benefits. This assures that both you and the dentist will know in advance how much of the dentist's charges the plan will pay. Most dentists are familiar with predetermination procedures.

Here's how it works:

The dentist informs Provident of the proposed

Predetermination of benefits can help you avoid surprises. Remember that the plan has a maximum amount it will pay in a calendar year.

If you do not ask for predetermination of benefits, Provident will pay the claim based on whatever information it has available. Predetermination of benefits could save you money by allowing you to consider alternate procedures (see the section, "Alternate Procedures").

If your dentist submits a treatment plan for predetermination of benefits and then changes the plan, Provident will adjust its payments accordingly. If changes in the treatment plan are major, the dentist should submit a revised plan.

NOTE: As indicated on the claim form's instruction sheet, to receive determination of payment levels, the dentist must submit X-rays to Provident for all crowns, bridge work, gold restorations and impacted teeth extractions.

Coordination of Benefits (COB)

The growing number of dental plans and the increasing number of two-income families mean that many people are covered or have the opportunity to be covered under more than one group plan. If you or your spouse or your dependents are eligible for more than one group plan, payments from all the plans combined will not exceed 100 percent of the allowable expenses.

An allowable expense is any necessary, reasonable and customary charge for dental services or treatment covered in whole or in part under the Dental Assistance Plan. Any items contained in the list of exclusions of this Dental Assistance Plan will not be considered an allowable expense, even if they are covered under another plan.

When claims are made under this Dental Assistance Plan and you or your covered family member is also covered by another group plan, it must first be determined which plan has primary responsibility and which plan has secondary responsibility.

When the other plan has a coordination of benefits provision, here's how primary responsibility is determined:

This dental assistance plan employee is	Other insurance	Dental expenses of	Who pays first	Who pays second
Husband	Wife's employer	Husband	We do	They do
		Wife	They do	We do
		Child	*	*
Wife	Husband's employer	Husband	They do	We do
		Wife	We do	They do
		Child	*	*

*When this plan and another plan cover the same child as a dependent of different persons, called parents, primary coverage comes from the plan of the parent whose birthday falls earlier in a calendar year (the "birthday rule").

If both parents have the same birthday, the plan which covered the parent longer is primary and the plan which covered the other parent for a shorter period of time is secondary.

Some plans do not use the birthday rule as described above, but instead use a rule based on the gender of the parent. If, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

When the other plan does not have a coordination of benefits provision, that plan is always primary and will pay first.

When primary, this Dental Assistance Plan will provide its regular benefits. When secondary, it pays the difference, if any, up to covered billed charges or the schedule amount, whichever is less.

NOTE: There is no COB between DAP and BellSouth Enterprises' Flexible Benefit Plan. This means that DAP never provides secondary coverage when primary coverage is provided by one of these plans.

Examples of How the Plan Works

Here are three examples of how the plan can work for you and your family.

EXAMPLE 1:

Your spouse goes to the dentist for the first time since coverage became effective. The dentist examines and takes X-rays of the patient's teeth, charts present dental condition and takes a dental history. For all these Type A services, the dentist charges $50.

As a result of the exam, the dentist fills five teeth (10 surfaces) and charges $190 for these Type B services.

The plan pays 100 percent of charges for the Type A services—in this case $50, which is determined to be reasonable and customary. For the Type B services, the schedule allows $165. Assuming your spouse had not obtained Type A preventive treatment in the last 12 months, the $25 deductible applies. So the plan payment for Type B services is $140.

Here is a summary of the claim payment:

	Dentist's charge	*Plan pays*	*Employee pays*
Type A Services	*$ 50*	*$ 50*	*$ 0*
Type B Services	*190*	*140**	*50*
TOTAL	*$240*	*$190*	*$ 50*

**Schedule allowance of $165 minus deductible of $25 equals $140 benefit.*

The employee has now satisfied the calendar year $25 deductible for this dependent. All future claims during this calendar year for this dependent will be paid without a deductible.

EXAMPLE 2:

After a dentist's examination and X-rays reveal serious dental disease, you have three upper teeth extracted and replaced by a partial denture. The exam and X-rays are Type A services, while the extractions and denture are Type B services.

Assuming you had already satisfied the calendar year $25 deductible, here is a summary of the claim payment:

	Dentist's charge	*Plan pays*	*Employee pays*
Type A Services			
Exam & X-rays	*$ 40*	*$ 40*	*$ 0*
Type B Services			
Extractions	*90*	*74*	*16*
Denture	*525*	*407*	*118*
TOTAL	*$655*	*$521*	*$134*

NOTE: Because of the nature and complexity of the dental treatment required, predetermination of benefits was used. See the section "Predetermination of Benefits."

EXAMPLE 3:
Your 16-year-old child has a malocclusion, and needs corrective orthodontic treatment (braces) to remedy the condition. Orthodontic treatment is always a Type B expense.

Assuming your child has Type A preventive treatment on a regularly scheduled basis, the $25 deductible will be waived each calendar year.

The following is a summary of the claim payment:

Date of service	Service	Dentist's charge	Plan pays	Employee pays
January 1993	Preliminary study	$ 100	$ 96	$ 4

Provident so it may process your claim. This authorization must be signed as described on the form. This part also authorizes Provident to pay the dentist directly for work performed for you and members of your family. You must sign the claim (as the employee) to certify the accuracy of the information given in Part 1.

The dentist must submit X-rays with the claim form whenever the treatment plan contains charges for extracting impacted teeth, gold restorations, crowns, dentures and bridge work. Provident will return the X-rays promptly.

File a claim when a course of treatment is complete. Make sure all lines are completed on the claim form to eliminate any delay in processing your claim.

The provider or participant must file the claim no later than 12 months from the date of the treatment. Claims received after one year from the date the expenses were incurred will not be covered or paid.

Payment of Benefits

Provident Life and Accident Insurance Company processes the claims for benefits provided by this plan under an administrative services agreement with BellSouth Corporation.

Claim Denial

If you have a question about Provident's decision on your claim, you should contact Provident's Dental Claim Unit. When discussing your claim, please refer to the explanation of payment, the claim form and other correspondence you may have received from Provident. Use the toll-free telephone number shown on your claim form to contact Provident.

If a claim for plan benefits is denied, in whole or in part, you or your dependent will receive written notification from the Provident Life and Accident Insurance Company. This written notification will include:

- The specific reason or reasons for the denial.
- Specific reference to pertinent plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to perfect your claim, and an explanation of why you must supply such material or information.
- Appropriate information about the steps you or your dependent or a duly authorized representative must take if you wish to submit the claim for review.

If you do not hear from Provident within 90 days after it receives your claim, submitted according to the procedures in the section, "Filing a Claim," your claim is considered denied.

Cost

If you are a regular full-time employee, the company pays the full cost of coverage for you, your spouse and other dependents, beginning on the date you complete six months of service.

If you are a regular part-time employee who was hired or re-engaged (after a break in service) on or after Jan. 1, 1990, and who works less than 37.5 hours in a week, you will pay a portion of the cost of your coverage, based on the ratio of your weekly hours worked to a 37.5-hour work week.

For example, if you work 7.5 hours each day for three days a week (a total of 22.5 hours each week, or 60 percent of a 37.5-hour work week),

the company will pay 60 percent of the cost of your coverage, either individual, two-party or family. You will be required to pay the remaining 40 percent of the cost.

If you are a regular part-time employee who

including temporomandibular joint dysfunction or TMJ, except oral splints.

- Replacing lost or stolen appliances.
- Extra sets of dentures or other appliances.
- Work that is otherwise free of charge to patients.

If You Leave the Company

Your coverage and coverage for all your dependents ends on the last day of the month in which you leave the company, die or fail to make a required payment while on an approved leave of absence or layoff.

Coverage of a dependent ends on the last day of the month in which the individual ceases to be an eligible dependent (turns 20, graduates from college, etc.).

For special coverage extension, see the section, "COBRA Benefits."

If you have eight or more years of service and terminate under the Career Alternative Plan (CAP), you may be eligible for up to 36 months of continued coverage at the company's expense.

The plan will not pay for services or supplies furnished after coverage terminates, even if Provident has predetermined the payments for a treatment plan submitted before you leave the company. But under the extension of benefits provision, the plan will pay the scheduled amounts for:

- A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the supporting (called "abutment") teeth while you were covered, and delivers and installs the device within two calendar months after coverage stops.
- A crown if the dentist prepared the tooth for the crown while you were covered by the plan, and installs the crown within two calendar months after coverage stops.
- Root canal therapy if the dentist opened the tooth while you were covered and completes the treatment within two calendar months after coverage stops.

Leave of Absence or Layoff

While you are on an approved leave of absence, other than for military service, you can continue your Dental Assistance Plan coverage by paying the full cost of the plan for yourself and your eligible dependents. If you decide not to pay the cost, your coverage stops at the end of the month you go on leave. Coverage resumes on the first of the month after you return to work.

If you are eligible for company-paid coverage and take a leave of absence for the care of a newborn child or for dependent care, the company pays the full cost of coverage for the first six months.

If you are laid off, you can continue your dental assistance coverage for 90 days by paying the full cost of the plan for yourself and your dependents. If you decide not to pay the cost, your coverage stops at the end of the month in which you are laid off. Coverage resumes on the first of the month after you return to work.

Retirement

If you retire from the company on a service or disability pension, the company currently intends to continue your coverage and coverage for your eligible dependents (who were covered prior to the date of your retirement) during your retirement through the last day of the month in which you die. However, the company reserves the right to change or modify coverage, including reduction, elimination of coverage, or requiring retirees to pay all or a greater portion of the cost of coverage, at its discretion.

NOTE: If you retire on or after Jan. 1, 1988, you may provide coverage for any eligible dependent other than your spouse added to your contract by paying the full premium rate for each additional dependent.

Competitor Rule and Benefit Forfeiture

If you retired on or after Jan. 1, 1991, you may forfeit your right and your dependents' right to certain post-retirement benefits if you provide services to or acquire an interest in a BellSouth competitor during the five years following retirement from BellSouth. **Please note that once such coverage is terminated, it will not be reinstated.**

Definition of a Competitor

A competitor of BellSouth or its affiliates is one who, in BellSouth's judgment, is engaged directly or through an affiliate in any line of business in which BellSouth or one or more of its affiliates is engaged, such as, but not limited to: the provision of telecommunications goods or services; the printing, publication, or provision of classified directories; the provision of cellular communications; and the provision of paging goods or services.

As set forth in the BellSouth Medical Assistance Plan, Dental Assistance Plan, Group Life Insurance Plan, and the Death Benefit provisions of the Pension Plan or the Management Pension Plan, a former employee will forfeit entitlement to post-retirement benefits under the foregoing plans if, during the five-year period following the employee's retirement:

- The employee acquires ownership of more than 5 percent of any class of stock of, or acquires beneficial ownership of, more than 5 percent of the earnings or profits of a competitor, or
- The employee becomes employed by, renders services to, or consults with a competitor, unless the employee's activities on behalf of the competitior make no use, directly or indirectly of:
  - BellSouth proprietary or customer information, or
  - Skills that the employee developed or used, or training provided to the employee during the last five years of the employee's employment by BellSouth or any of its affiliates.

During the five-year period over which the Forfeiture Provision is applicable, the business activities of BellSouth and its affiliates at the time that a former employee acquires an ownership interest in, or becomes employed by, changes assignments with, renders services to, or consults with another business entity will determine whether that entity is a competitor.

Health and welfare benefits are deemed terminated upon the date of occurrence of the forfeiture event, i.e., the date that more than 5 percent ownership interest in a competitor is acquired, or the date that employment with a competitor is begun. Upon learning of a forfeiture event, BellSouth reserves the right to seek the reimbursement of any benefits that were paid following the occurrence of that event.

Request for Benefit Forfeiture Ruling

An employee may file a "Request for Benefits Forfeiture Ruling" with the retiree benefit organization before acquiring an ownership or beneficial interest in another entity or before engaging in any post-retirement employment activity. On the basis of the information included in the request, the employee will receive a binding determination, based on the activity described in the request, as to whether the entity is a competitor, and if applicable, if the activity in question is deemed to be in competition with BellSouth.

Employees who disagree with the response that they receive to a Request for Benefits Forfeiture Ruling may request to have that response reviewed. In order to prevent a possible forfeiture, such a review should be indicated and completed before engaging in the activity at issue.

The addresses of the various company Employees' Benefit Committees are listed below:

- BellSouth Business Systems
- BellSouth Communications, Inc.
- BellSouth Communications Systems
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Telecommunications, Inc.
- BellSouth Financial Services Corporation

Room 18H62 Southern Bell Center
675 W. Peachtree Street, N.E.
Atlanta, Georgia 30375

- BellSouth Advertising & Publishing Corporation
- BellSouth Enterprises, Inc.
- BellSouth Information Systems, Inc.
- BellSouth International, Inc.
- BellSouth Mobility Inc
- BellSouth Resources, Inc.
- Sunlink Corporation
- Intelligent Media Services, Inc.
- Intelligent Messaging Services, Inc.

Room 5C08
1100 Peachtree Street, N.E.
Atlanta, Georgia 30309

Appeal of Benefit Forfeitures

Employees who have their benefits eligibility terminated under the Forfeiture Provision may, on their own behalf or through a representative, have that action reviewed by submitting a written appeal within 60 days of their receipt of the notification of termination of eligibility to the secretary of their company's Employees' Benefit Committee at the address shown previously.

If the appeal is denied, the employee will receive written notice of the Employees' Benefit Committee's decision, including the specific reasons for the decision and the procedures for appealing the decision, within 90 days of the date the committee received the appeal.

In some cases, the committee may need more than 90 days to make a decision. In such cases, the committee will notify the employee in writing within the initial 90-day period and explain why more time is needed. An additional 90 days may be taken to make the decision if the committee sends this notice. The extension notice will show the date by which the committee's decision will be sent. If the committee does not give its decision within the designated time span, the appeal is deemed to be denied.

An employee whose appeal to the Employees' Benefit Committee is denied, or deemed denied where no reply is received within 90 days, or if an extension was requested, within 180 days, may challenge such a denial by submitting a written appeal to the secretary of the BellSouth Corporation Employees' Benefit Claim Review Committee at the following address:

Room 1927
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000.

Such an appeal must be submitted in writing within 60 days after the receipt of the Employees' Benefit Committee's denial notification, or if no denial is received, within 60 days of the date that the original appeal was deemed to be

denied. The Employees' Benefit Claim Review Committee will conduct a review and issue a determination within 60 days after receipt of the appeal. In some cases, the Claim Review Committee may need more than 60 days to make a decision. In such cases, the Claim Review Committee will notify the employee in writing within the initial 60-day period and explain why more time is needed. The Employees' Benefit Claim Review Committee may then have 60 days more, or a total of 120 days, in which to make its decision.

The Employees' Benefit Claim Review Committee will issue a final written decision that will include specific reasons for the decision. If the Employees' Benefit Claim Review Committee does not issue its decision within the appropriate time span, the appeal is deemed to be denied.

In submitting an appeal either to the Employees' Benefit Committee or the Employees' Benefit Claim Review Committee, the employee is entitled to include a written statement of the issues and any other documents in support of the appeal. All material provided to either committee will be carefully considered in the determination.

BellSouth has delegated to the company Employees' Benefit Committees and the BellSouth Corporation Employees' Benefit Claim Review Committee the duty to administer the appeal of benefit eligibility terminations under the Forfeiture Provision. The company Employees' Benefit Committees and the BellSouth Employees' Benefit Claim Review Committee have the discretion and authority to interpret and to enforce the Forfeiture Provision, and their determinations and interpretations are final and conclusive.

As a participant in the various benefit plans subject to the Forfeiture Provision, you have further rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Those rights are described in detail in the summary plan descriptions issued for each affected plan.

Service or Disability Pension After Jan. 1, 1992

Employees retiring after Jan. 1, 1992, are subject to paying a portion of the cost of their retiree health care coverage. Beginning Jan. 1, 1993, and each year thereafter, your share of the cost for retiree coverage will be the excess of the capped amount (1990 actual cost level increased 11.4 percent) for two years in arrears from the current year.

For management employees, a premium will not be required until the costs exceed the capped amount (the 1990 actual cost level plus 11.4 percent). This is estimated to occur on Jan. 1, 1994.

For non-management employees, as a result of 1992 bargaining, a premium will not be required prior to Jan. 1, 1996. In addition, a Retiree Premium Offset Fund was established for non-management employees that will be applied toward the premium cost.

COBRA Benefits

On April 7, 1986, Congress enacted a federal law—the Consolidated Omnibus Budget Reconciliation Act (COBRA)—requiring that most employers who sponsor group health plans offer employees and their dependents the opportunity for temporary extension of health

coverage in certain situations where that coverage would otherwise end. This coverage, called COBRA coverage, is available at 102 percent of group rates. The Dental Assistance Plan is considered a group health plan.

The information in this section provides a summary of your rights and obligations under COBRA. You, your spouse and your other covered dependents should read this section carefully.

If you are an active, regular employee (or a regular employee on an approved leave of absence) covered by the BellSouth Dental Assistance Plan, you have a right to choose COBRA coverage for yourself and your covered dependents if you lose coverage because your employment has been terminated. This includes:

- termination because of retirement or
- a reduction in hours, but does not include termination for reasons of gross misconduct on your part.

occur within 18 months of retirement);

- termination of the covered employee's employment for reasons other than gross misconduct, including retirement or a reduction in the covered employee's hours;
- divorce, or
- the dependent ceases to be a dependent under the provisions of the plan; for example, because of age or financial dependency (for dependent of a retiree, change in status must occur within 18 months of retirement).

Under the law, you or a family member has the responsibility to inform the Benefit Office within 60 days after losing coverage because of divorce or because a dependent has ceased to meet the criteria outlined in the section "Eligibility." The company has the responsibility to notify the appropriate Benefit Office of an employee's death or termination of employment.

When the Benefit Office is notified that one of these events has happened, it will notify you that you have the right to choose COBRA

maintain COBRA coverage for 36 months, unless you lost coverage because of a termination of employment, including retirement or a reduction in hours. In those cases, the required COBRA coverage period is 18 months. However, the 18-month period may be extended to a 29-month period if you are receiving Social Security disability benefits.

If you continue to receive benefits at company expense following one of the events that trigger COBRA coverage (i.e., you separate employment under the Career Alternative Plan), you may not want to begin paying the COBRA-required premium until your company-sponsored coverage ends.

Please note, however, that your COBRA eligibility period will run concurrently with the time period that you receive company-paid benefits. In such cases, therefore, you would be eligible for COBRA coverage only for the balance of the COBRA eligibility period that remained following the expiration of company-paid benefits.

The law also provides that your COBRA coverage may be cut short for any of the following reasons:

- The company no longer provides group dental coverage to any of its employees;
- The charge for your COBRA coverage is not paid on a timely basis; or
- You become covered as an employee or otherwise under another group plan.

You do not have to show that you are insurable to choose COBRA coverage. However, under the law, you will have to pay up to 102 percent of the group rate for your COBRA coverage during your 18-month or 36-month continuation coverage period. In addition, if you are receiving Social Security disability benefits, the cost of your COBRA coverage will be 150 percent of the group rate. At the appropriate time, the company will provide you with information on how to elect continued coverage under COBRA.

At the end of the COBRA coverage period, your coverage under the Dental Assistance Plan ends. There is no conversion allowed under the Dental Assistance Plan.

Plan Continuance

The company currently intends to continue the Dental Assistance Plan but reserves the right to amend or terminate it at any time, subject to any applicable collective bargaining agreements. No amendment or termination shall affect payment of benefits already received prior to plan amendment or termination.

The benefits described in this summary plan description reflect the provisions of the Dental Assistance Plan as outlined in current agreements, if any, between the "participating companies" and the various unions representing employees of those companies in collective bargaining units. Copies of these agreements are distributed or made available to employees covered by them.

Other Important Information

The name of this plan is the BellSouth Dental Assistance Plan. The plan is classified under the Employee Retirement Income Security Act of 1974 (ERISA) as a welfare plan. The group plan described in this summary plan description provides only dental coverage.

Plan Funding

BellSouth currently provides for the payment of plan benefits through one of two established trusts, one for management employees and the other, which is a negotiated trust, for non-management employees. These trusts fund active health benefits for employees and their covered dependents. The trusts also accept participant contributions for vision coverage. In addition, the participating companies make periodic contributions to the trusts to meet the plan's obligations. The trustee of both trusts is:

Nation's Bank
Master Trust - Southeast
7th Floor
600 Peachtree Street, N.E.
Atlanta, Georgia 30308

Contributions for coverage are made by the company and by employees when required.

Benefit payment checks that are not cashed within 90 days after the date of the check will be considered null and void and the benefit paid will be forfeited. Any forfeited benefit may be reconsidered by filing a claim for the forfeited amount within 12 months from the date of treatment and satisfactorily demonstrating entitlement to the payment.

Plan Administrator

The plan administrator is:

BellSouth Corporation
Room 7B09
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000
Telephone: (404) 249-2328.

BellSouth Corporation has delegated responsibility for handling plan administrative services for the employees of each company as follows:

- BellSouth Advertising & Publishing Corporation (non-management employees only)

  Assistant Secretary
  BellSouth Enterprises
  Employees' Benefit Committee
  59 Executive Park South, N.E.
  Atlanta, Georgia 30329
  Telephone: (404) 982-7027

- BellSouth Communications, Inc.
- BellSouth Financial Services Corp.
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Communications Systems
- BellSouth Business Systems
- BellSouth Telecommunications, Inc.

  ACTIVES:
  Secretary
  Employees' Benefit Committee
  Suite 1400
  3000 Riverchase Galleria
  Birmingham, Alabama 35244
  Telephone: 1-557-6179 (Local service provided by South Central Bell.)
  780-2029 (Local service provided by Southern Bell.)
  (205) 733-3001, call collect (Local service provided by any other company.)

  RETIREES:
  Operations Manager
  BellSouth Benefits Administration
  P.O. Box 54299
  Atlanta, Georgia 30308-0299
  Telephone: 1-557-6666 (Local service provided by South Central Bell.)
  780-2025 (Local service provided by Southern Bell.)
  1-800-842-1558 (all others)

Plan Administration

BellSouth has delegated to Provident Life and Accident Insurance Company, Fountain Square, Chattanooga, Tennessee 37402, the duty to administer all claims for plan benefits for all participating companies. The Administrative Services Agreement between BellSouth Corporation and Provident governs the operation of the plan at all times. This agreement designates Provident as claims administrator.

Provident, with regard to administrative services delegated to it, has the sole and exclusive contained in the Administrative Services Agreement between Provident Life and Accident Insurance Company and BellSouth Corporation, which legally governs the operation of the plan.

As a plan participant, you are entitled to examine, without charge, plan documents, including the Administrative Services Agreement, the annual report of plan operations, and other documents and reports that are maintained by the plan or filed with a federal agency. These documents are available for review during normal working hours at your Benefit Office.

Appeal of Claim Denial

If a claim for benefits is denied, you, your dependent or a duly authorized person may appeal this denial or other action in writing, within 60 days after you receive notification of Provident's decision. If Provident does not send any notification, you may file your appeal within 60 days after the 90-day period discussed "Claim Denial." Send written requests for review of any denied claim or any other disputed matters directly to the Provident Life and Accident Insurance Company, Dental Claim Unit, Post Office Box 182558, Chattanooga, Tennessee 37422.

The person sending a request has the right to:
- Review pertinent plan documents. You may get these documents by following the procedures outlined in the section "Plan Documents."
- Send to Provident a written statement and any other documents in support of your claim for benefits or other matters under review.

Provident will provide you a written response to the appeal within 90 days after it is received. If Provident denies your claim again, you may have further rights under ERISA; see the section "Your Rights Under ERISA."

Help

If you need to file a claim or ask a question about the Dental Assistance Plan, write to Provident at the following address:

Provident Life and Accident
Insurance Company
P.O. Box 182558
Chattanooga, Tennessee 37422

or call one of the following toll-free numbers:

Outside Tennessee	1-800-251-6401
Tennessee	1-800-572-7343
Chattanooga	755-3100

Participating Companies

The Dental Assistance Plan is available to the following participating companies (referred to in this summary plan description as "the company" or "companies") who are eligible for coverage under this plan.
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Advertising & Publishing Corporation (retirees and non-management employees only)
- BellSouth Communications, Inc.
- BellSouth Financial Services Corporation
- BellSouth Telecommunications, Inc.
- BellSouth Communications Systems
- BellSouth Business Systems

The following companies participate for retirees only.
- BellSouth Enterprises, Inc.
- BellSouth Information Systems, Inc.
- BellSouth International, Inc.
- BellSouth Mobility Inc
- BellSouth Resources, Inc.
- Sunlink Corporation
- Intelligent Media Services, Inc.
- Intelligent Messaging Services, Inc.

This list of participating companies may change. Contact your Benefit Office if you have any questions about whether your employer is a participating company.

Your Rights Under ERISA

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to safeguard your interests and those of your beneficiaries under your employee benefit plans. As ERISA requires, this section provides a statement of your rights and protections under this law.

ERISA does not require a company to provide benefits, but does set standards for any benefits a company wishes to offer—and it requires that you be given an opportunity to learn what these benefits are and your rights to them under the law.

It is your right to know as much as possible about your benefits. This summary plan description is one way to help keep you informed.

As a participant in the Dental Assistance Plan, you are entitled to certain rights and protections under ERISA.

- You may examine, without charge, at the plan administrator's office and at other specified locations, all plan documents, including contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor. This includes detailed annual reports and plan descriptions.
- You may obtain copies of all plan documents and other plan information by requesting them in writing from the plan administrator. The administrator may make a reasonable charge for the copies.
- You may receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in your interest and in the interest of 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 a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right under the plan to request a review and reconsideration of your claim.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials 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 pay you up to $100 day until you receive the materials, unless they were not sent for reasons beyond the administrator's control.

If you have a claim for benefits which is denied or ignored, in whole or in part, after you have exhausted the plan's appeal program, you may file suit in a state or 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 sued to pay these expenses. If you lose, the court may order you to pay these costs and fees. For example, the court may order you to pay costs and fees if it finds your claim frivolous.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated

against for asserting your rights, you may seek help from the U.S. Department of Labor, or you may file suit in a federal court.

If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the U.S. Labor Management Services Administration, Department of Labor.

Additional Information

This booklet provides the summary plan description of the Dental Assistance Plan as required by ERISA. More complete details are contained in the Administrative Services Agreement between Provident Life and Accident Insurance Company and BellSouth Corporation. It may be obtained or looked at by following the instructions under the section, "Plan Documents." Since this summary plan description only summarizes and does not have all details of the plan, the Administrative Services Agreement governs in all cases.

Appendix I: Location List

Usual and customary charges for dental services vary depending on the location of the dentist's office.

To find out what your scheduled allowances are for Part B services, follow these steps:

- Consult the location list below to find out which schedule applies to you. It is keyed to the dentist's location.

- Refer to "Appendix II: Schedule of Payment for Services" on the following pages to determine benefits payable.

Dentist's location	Look at schedule #
Alabama	
City of Montgomery (zip codes beginning 361 only)	2
Remainder of state (including zip code 369)	1
Alaska	
	2
Arizona	
	2
Arkansas	
City of Little Rock (zip codes beginning 722 only)	2
Remainder of state	1
California	
Greater Los Angeles (zip codes beginning 900-918 & 926-931 only)	4
Greater San Francisco (zip codes beginning 940-951 only)	4
Remainder of state	3
Colorado	
Greater Denver (zip codes beginning 800-803 only)	3
Remainder of state	2
Connecticut	
New London (zip codes beginning 063 only)	2
Waterbury area (zip codes beginning 067 only)	2
Remainder of state	3
Delaware	
City of Wilmington (zip codes beginning 198 only)	3
Remainder of state	2

District of Columbia	3
Florida	
Pensacola area (zip codes beginning 324-325 only)	2
Orlando area (zip codes beginning 327-329 only)	2
Tampa/St. Petersburg (zip codes beginning 335-337 only)	2
Remainder of state (including zip codes 349 and 346)	3
Georgia	
City of Atlanta (zip codes beginning 303 only)	3
Atlanta area (zip codes beginning 300-302 only)	2
Greater Savannah (zip codes beginning 313-314 only)	2
Remainder of state	1
Hawaii	3
Idaho	2
Illinois	
Chicago and area (zip codes beginning 600-606 only)	3
Remainder of state	2
Indiana	
Indianapolis area (zip codes beginning 460-462 only)	2
Gary, South Bend, Ft. Wayne and surrounding areas (zip codes beginning 463-469 and 473 only)	2
Remainder of state	1
Iowa	1
Kansas	2
Kentucky	1
Louisiana	
City of Baton Rouge (zip codes beginning 708 only)	3
Remainder of state	2
Maine	1

Maryland	3
Massachusetts	2
Michigan	
Detroit area (zip codes beginning 480-483 only)	4
Flint (zip codes beginning 485 only)	3
Lansing (zip codes beginning 489 only)	3
Grand Rapids (zip codes beginning 495 only)	3
Remainder of state	2
Minnesota	
Minneapolis-St. Paul (zip codes beginning 551-554 only)	2
Remainder of state	1
Mississippi	
City of Jackson (zip codes beginning 392 only)	2
Remainder of state	1
Missouri	
Greater St. Louis (zip codes beginning 630-633 only)	2
Greater Kansas City (zip codes beginning 640-641 only)	2
Remainder of state	1
Montana	2
Nebraska	
City of Omaha (zip codes beginning 681 only)	2
Remainder of state	1
Nevada	4
New Hampshire	2
New Jersey	
Southern New Jersey (zip codes beginning 080-084 only)	2
Remainder of state	3
New Mexico	2

New York	
Westchester & Putnam Counties (zip codes beginning 105-108 only)	3
Northern NY state (zip codes beginning 128, 129, 136 only)	1
Southern NY state (zip codes beginning 127, 137-139, 147, 148-149 only)	1
Remainder of state	2
North Carolina	2
North Dakota	1
Ohio	
Greater Cleveland (zip codes beginning 440-441 only)	3
Greater Cincinnati (zip codes beginning 450-452 only)	1
Remainder of state	2
Oklahoma	
Oklahoma City area (zip codes beginning 730-731 only)	2
Tulsa area (zip codes beginning 740-741 only)	2
Remainder of state	1
Oregon	2
Pennsylvania	
City of Pittsburgh (zip codes beginning 152 only)	3
Remainder of state	2
Rhode Island	2
South Carolina	
Charleston area (zip codes beginning 294 only)	2
Remainder of state	1
South Dakota	1
Tennessee	
City of Nashville (zip codes beginning 372 only)	2

Texas	
City of Houston (zip codes beginning 770-772 only)	4
Houston area, including Beaumont (zip codes beginning 773-777 only)	3
Dallas, Fort Worth, Waco (zip codes beginning 750-752, 760-761, 766-767 only)	3
Corpus Christi area (zip codes beginning 783-785 only)	3
City of Austin (zip codes beginning 787 only)	3
Lubbock area (zip codes beginning 793-794 only)	3
Remainder of state	2
Utah	1
Vermont	1
Virginia	
Washington, D.C., area (zip codes beginning 220-223 only)	3
Remainder of state	2
Washington	
Seattle, Tacoma and area (zip codes beginning 980-984 only)	3
Remainder of state	2
West Virginia	
Charleston area (zip codes beginning 250-253 only)	2
Wheeling area (zip codes beginning 260 only)	2
Remainder of state	1
Wisconsin	2
Wyoming	2
Outside U.S.A.	2

NOTE: Schedules reflect differences in dental benefits by geographic area.

Appendix II: Schedule of Payment for Services

Partial listing of schedules of allowances for Type B services most commonly performed.

SERVICES	SCHEDULES			
Restorations	**1**	**2**	**3**	**4**
Amalgam one surface deciduous	$ 21	$ 24	$ 28	$ 31
Amalgam two surfaces deciduous	28	32	36	41
Amalgam three surfaces deciduous	33	39	43	48
Amalgam one surface permanent	22	25	28	31
Amalgam two surfaces permanent	29	33	39	43
Amalgam three surfaces permanent	35	42	47	53
Silicate cement — per restoration	20	23	25	29
Acrylic or plastic	20	23	25	29
Composite resin — one surface	25	29	33	35
Composite resin — two surfaces	33	39	43	48
Composite resin — three surfaces	42	48	56	62
Inlay, gold — two surfaces	208	239	272	303
Inlay, gold — three surfaces	216	249	281	314
Crowns				
Plastic with semiprecious metal crown	231	266	303	337
Full porcelain crown	267	307	348	387
Porcelain with semiprecious metal crown	248	286	322	360
Gold full cast crown	253	292	329	367
Gold 3/4 cast crown	254	295	332	372
Stainless steel crown	55	64	73	80
Pulp cap — direct	13	15	18	20
Root Canal Therapy				
One canal (traditional)	154	176	201	229
Two canals (traditional)	204	235	265	296
Three canals (traditional)	237	273	309	344
Periodontics				
Gingival curettage — per quadrant	39	44	50	57
Gingivectomy — per quadrant	99	113	129	144
Osseous surgery — including flap entry and closure per quadrant	244	281	318	354

Prosthodontics

Complete dentures including six months' post-delivery care				
Complete upper	338	391	441	493
Complete lower	328	377	428	477
Immediate upper	355	409	463	517
Immediate lower	328	377	428	477
Partial dentures including six months' post-delivery care				
Upper with two chrome clasps	349	403	455	508
Lower with chrome lingual bar, two clasps, acrylic base	344	397	450	502
Lower with chrome lingual bar, two clasps, cast base	342	394	446	497
Upper with chrome palatal bar, two clasps, acrylic base	354	407	461	515
Upper with chrome palatal bar, two clasps, cast base	329	380	430	480
Full cast partial with two chrome clasps (upper)	377	433	490	547
Bridge pontics				
Cast gold	242	278	315	352
Slotted pontic	210	242	274	306
Porcelain fused to semi-precious metal	241	277	314	351
Plastic processed to semi-precious metal	238	273	309	344

Oral surgery

Simple extractions				
Single tooth	22	26	29	33
Each additional tooth	21	24	28	31
Surgical Extractions				
Extraction of tooth, erupted	40	45	52	57
Extraction of tooth, partial bony impaction	88	102	116	129
Extraction of tooth, complete bony impaction	106	121	138	154

Orthodontics (maximum lifetime benefit $1,100 for covered persons age 20 or over, and $1,452

Appendix III:
Glossary of common dental terms

Abutment: Terminal tooth or root that retains or supports a bridge or a fixed or removable prosthesis.

Anesthesia:
Local: The condition produced by the administration of specific agents to achieve the loss of
conscious pain response in a specific location or area of the body.
General: The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Dental hygienist: A person who has been trained and licensed to remove calcareous deposits and stains from the surfaces of the teeth (clean your teeth), and to provide additional services and information on the prevention of oral disease.

Dentist: A person duly licensed to practice dentistry by the governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in this dental expense plan, the term "dentist" also includes a licensed physician authorized by his license to perform the particular dental service he has rendered.

Denture: A device replacing missing teeth.