

# Health and Welfare Plans Combined Summary

January 1, 2026 – December 31, 2026



T-Mobile USA has prepared this summary to help our employees better understand the benefits available to them. **This summary, however, is not intended to be a legal document.** For specific plan questions and a complete list of limitations and exclusions, please refer to the plan certificate from HMSA regarding Medical benefits, or the T-Mobile Summary Plan Description for all other plans illustrated here.

PLAN PROVISIONS	HMSA HMO		HMSA PPO	
	<i>In-Network</i>		<i>Participating Providers</i>	<i>Nonparticipating</i>
Overall Deductible (annual)	\$0		For participating providers \$0 For non-participating providers \$100 per person Maximum: \$300 per family Doesn't apply to contraceptives, emergency services, prescription drugs and supplies, preventive care and well-child care.	
Out-of-pocket Limit (annual)	\$2,500 per person/\$7,500 per family (medical plan coverage) \$3,600 per person/\$4,200 per family (prescription drug coverage)		\$2,500 per person/\$7,500 per family (medical plan coverage) \$3,600 per person/\$4,200 per family (prescription drug coverage)	
	<b>YOUR COST</b>		<b>YOUR COST</b>	
<b>If you visit a health care provider's office or clinic</b>				
Primary Care or Specialist Visit	\$20 copay/visit		\$12 copay/visit	30% co-insurance
Preventive care (Well Child Care Physician Visit through age 21)	No charge		No charge	30% co-insurance
Screening (Grade A & B recommendations of the U.S. Preventive Services Task Force)	No charge		No charge	30% co-insurance
Immunization (standard and travel)	No charge		No charge	30% co-insurance
<b>If you have a test</b>				
Diagnostic Test	10% co-insurance (inpatient) 20% co-insurance (outpatient)		10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
X-ray	10% co-insurance (inpatient) \$10 copay (outpatient)		10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
Blood Work	10% co-insurance (inpatient) \$10 copay (outpatient)		10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
Imaging (CT/PET scans, MRI's)	10% co-insurance (inpatient) 20% coinsurance (outpatient)		10% co-insurance (inpatient) 20% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
<b>If you have outpatient surgery</b>				
Facility fee (e.g., ambulatory surgery)	10% co-insurance		10% co-insurance	30% co-insurance
Physician Visit	\$20 copay/visit		\$12 copay/visit	30% co-insurance
Surgeon Fees	\$20 copay (cutting) \$20 copay (non-cutting)		10% co-insurance (cutting) 20% co-insurance (non-cutting)	30% co-insurance (cutting) 30% co-insurance (non-cutting)

MEDICAL SERVICES	HMSA HMO	HMSA PPO	
	YOUR COST	YOUR COST	
	In-Network	Participating Providers	Nonparticipating
<b>If you need immediate medical attention</b>			
Emergency Room Services – Physician Visit	No charge	\$12 copay/visit	\$12 copay/visit
Emergency Room Services – Emergency Room	\$100 copay/visit	20% co-insurance	20% co-insurance
Emergency Medical Transportation (air)	20% co-insurance	20% co-insurance	30% co-insurance
Emergency Medical Transportation (ground)	20% co-insurance	20% co-insurance	30% co-insurance
Urgent Care	\$20 copay/visit	\$12 copay/visit	30% co-insurance
<b>If you have a hospital stay</b>			
Facility Fee (e.g., hospital room)	10% co-insurance	10% co-insurance	30% co-insurance
Physician Visit	10% co-insurance	\$12 copay/visit	30% co-insurance
Surgeon Fee	10% co-insurance (cutting) 10% co-insurance (non-cutting)	10% co-insurance (cutting) 20% co-insurance (non-cutting)	30% co-insurance (cutting) 30% co-insurance (non-cutting)
<b>If you have mental health, behavioral health, or substance abuse needs</b>			
Mental / Behavioral Health Physician services	10% co-insurance (inpatient) \$20 copay/visit (outpatient)	10% co-insurance (inpatient) \$12 copay/visit (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
Mental / Behavioral Health Hospital and facility services	10% co-insurance (inpatient) No charge (outpatient)	10% co-insurance (inpatient) 10% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
Substance Use Disorder Physician services	10% co-insurance (inpatient) \$20 copay/visit (outpatient)	10% co-insurance (inpatient) \$12 copay/visit (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
Substance Use Disorder Hospital and facility services	10% co-insurance (inpatient) No charge (outpatient)	10% co-insurance (inpatient) 10% co-insurance (outpatient)	30% co-insurance (inpatient) 30% co-insurance (outpatient)
<b>If you are pregnant</b>			
Prenatal and Postnatal Care	No charge	10% coinsurance	30% co-insurance
Delivery (surgery)	10% co-insurance	10% co-insurance	30% co-insurance
Inpatient services (hospital room and board)	10% co-insurance	10% co-insurance	30% co-insurance
<b>If you need help recovering or have other special health needs</b>			
Home Health Care	No charge	No charge	30% co-insurance
Rehabilitation Services	\$20 copay/visit	20% co-insurance	30% co-insurance
Skilled Nursing Care	10% co-insurance	10% co-insurance	30% co-insurance
Durable Medical Equipment	20% co-insurance	20% co-insurance	30% co-insurance
Hospice Service	No charge	No charge	Not covered

MEDICAL SERVICES	HMSA HMO		HMSA PPO	
	YOUR COST		YOUR COST	
	In-Network		Participating Providers	Nonparticipating
<b>If your child needs eye care</b>				
Eye Exam (one exam per calendar year)	\$20 copay/exam		Not covered	Not covered
Glasses	Not covered		Not covered	Not covered
<b>ONLINE CARE</b>	As an HMSA member, you and your covered dependents may access HMSA's Online Care through <a href="http://www.hmsa.com">www.hmsa.com</a> .			

PRESCRIPTION DRUGS	HMSA HMO		HMSA PPO	
	YOUR COST		YOUR COST	
	Participating Provider	Nonparticipating Provider	Participating Provider	Nonparticipating Provider
<b>TIER 1:</b> MOSTLY GENERIC DRUGS	\$7 copay/prescription	\$7 copay and 20% co-insurance/prescription	\$7 copay/prescription	\$7 copay and 20% co-insurance/prescription
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.		One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.	
<b>TIER 2:</b> MOSTLY PREFERRED DRUGS	\$30 copay/prescription	\$30 copay and 20% co-insurance/prescription	\$30 copay/prescription	\$30 copay and 20% co-insurance/prescription
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.		One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.	
<b>TIER 3:</b> MOSTLY OTHER BRAND NAME DRUGS	\$30 copay/prescription plus \$45 Other Brand Name Cost Share	\$30 copay and 20% co-insurance/prescription plus \$45 Other Brand Name Cost Share	\$30 copay/prescription plus \$45 Other Brand Name Cost	\$30 copay and 20% co-insurance/prescription plus \$45 Other Brand Name Cost
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.		One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.	
<b>TIER 4:</b> MOSTLY PREFERRED SPECIALTY DRUGS	20% coinsurance	Not covered	20% coinsurance	Not covered
	Retail benefit limited to a 30-day supply.		Retail benefit limited to a 30-day supply.	
<b>TIER 5:</b> MOSTLY OTHER BRAND NAME SPECIALTY DRUGS	25% coinsurance	Not covered	25% coinsurance	Not covered
	Retail benefit limited to a 30-day supply.		Retail benefit limited to a 30-day supply.	

**MAIL SERVICE PRESCRIPTION PROGRAM  
(From an HMSA contracted provider)**

<b>TIER 1:</b> MOSTLY GENERIC DRUGS	\$11 copay/prescription	Not covered	\$11 copay/prescription	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.		One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
<b>TIER 2:</b> MOSTLY PREFERRED DRUGS	\$65 copay/prescription	Not covered	\$65 copay/prescription	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.		One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	

<b>TIER 3:</b> MOSTLY OTHER BRAND NAME DRUGS	\$65 copay/prescription plus \$135 <sup>(1)</sup> Other Brand Name Cost	Not covered	\$65 copay/prescription plus \$135 <sup>(1)</sup> Other Brand Name Cost	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.		One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
<b>TIER 4:</b> MOSTLY PREFERRED SPECIALTY DRUGS	Not covered	Not covered	Not covered	Not covered
<b>TIER 5:</b> MOSTLY OTHER BRAND NAME SPECIALTY DRUGS	Not covered	Not covered	Not covered	Not covered

**MAIL SERVICE PRESCRIPTION PROGRAM  
(From an HMSA contracted provider)**

- **NOTE:** When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you will be responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you chose not to use the generic equivalent or the particular generic equivalent was not available at the pharmacy.

(1) \$45 retail Other Brand Name cost share times 3-month supply

## LiveMagenta (including Optum EAP)

Confidential help anytime:  
(855) 780-5958

or

<https://livemagenta.com/>

- **Assessment and Counseling**—For employees and their households, up to ten visits provided at no cost per concern per plan year for emotional wellbeing, addiction, relationship troubles and more. Call 24/7 and speak confidentially with an Optum master’s level specialist or get a referral for in-person or online virtual visits. Live chat is available during business hours.
- **Calm app for employees on a UHC/Surest Medical plan** – free, on-demand support for stress, mindfulness and sleep.
- **Calm Health app** – support for mind and body, self-care courses and tools and personalized plans.
- **Talkspace – virtual therapy using secure audio and video messages.**
- **Financial Assistance My Secure Advantage**—Unlimited access to work with credentialed money coaches on financial planning, debt management, investments or other financial matters.
- **Quit for Life® & Live Vape Free** - quit tobacco program that includes coaching, text messaging, online learning and if you qualify Nicotine Replacement Therapy.
- **Sober Sidekick**- A confidential app offering a judgement-free space to connect, reflect, and grow—with peer chats, virtual AA-style meetings, access to recovery professionals, sobriety tracking and more.
- **Grokker**- all-in-one wellness app—eat better, move more, stress less, and sleep well. With unlimited access to expert-led videos and program, wellness is personalized, flexible, and always within reach.
- **Legal Assistance**—Legal services include one 30-minute initial consultation per personal legal matter with an attorney, plus get a 25% discount for ongoing services. Legal services address issues like landlord/tenant disputes, personal injury, or bankruptcy.
- **Family Mediation**—Access to information and/or referral to a mediator to resolve family disputes in lieu of pursuing litigation.
- **Child and Parenting Support Services**—Extensive services for families and children up to age 18, including information and consultation on all kinds of parenting questions, resources for daycare, summer camps, adoption, sick-child care, and more.
- **Adult and Elder Support Services**—Resources for people caring for adult and elder dependents, including caregiving and housing options, chronic illness support, transportation and meal services and senior activity groups.
- **Chronic Condition Support**—Valuable information and support services for employees and dependents who have a chronic illness like diabetes, heart disease, arthritis, or asthma.
- **Life Learning**—Educational resources for all ages and abilities, including help with locating and evaluating schools, finding classes for special needs children, and arranging tutoring services.
- **Convenience Services** – verified resources for a variety of situations including pet sitting, home improvement and repair, recreational activities and entertainment and dining.
- **[https://livemagenta.com](https://livemagenta.com/)**—A robust website with information and resources on a wide range of health and wellness topics:
  - Life Stages Help Centers—Providing information and resources on parenting, eldercare, anxiety and coping with chronic conditions.
  - On-line articles and resources on health, wellness and personal development. Learn to cope with stress, manage major life changes or balance work and life issues.
  - Personal plans and self-assessment tests—Use tools that will help you build communication skills, improve health and fitness or quit smoking.

## Get Help Navigating Healthcare With a Health Pro

[TMUSHealthPro@alight.com](mailto:TMUSHealthPro@alight.com)

(855) 496-0071

This service is through Alight and offers you a Health Pro, or personal healthcare advocate to assist with:

- Understanding your benefits and plan details
- Finding great doctors, dentists, and eye care professionals
- Comparing prices to save money on medical care
- Reviewing your healthcare claims
- Getting help with medical, dental and vision bills
- Researching alternatives to pay less for prescriptions
- Scheduling your appointments and transferring your medical records

Health Pro services are FREE if you are enrolled in one of T-Mobile’s medical, dental or vision plans.

<b>PPO Network Dental Plan—Delta Dental of Washington</b>	<b>Maximums and Limits</b>	<b>Delta Dental PPO Provider</b>	<b>Non-PPO Provider</b>
<b>Group #09037</b>	<b>(Plan Year is January 1 through December 31)</b>		
<b>Plan Year Deductible</b>	Waived on Class I Benefits, Orthodontic Benefits, and Accidental Injury Benefits	\$50 per individual \$150 per family	No coverage or benefits provided
<b>Class I Benefits</b>	Diagnostic and Preventive: Exams, cleanings, fluoride (through age 18), X-rays, and sealants  Accidental Injury Treatment	100%	No coverage or benefits provided
<b>Class II Benefits</b>	Restorative: Fillings, oral surgery, root canals, periodontics	80%	No coverage or benefits provided
<b>Class III Benefits</b>	Major: Crowns, dentures, bridges, partials, implants, dental night guards (covered at 50% for bruxism every 3 years)	50%	No coverage or benefits provided
<b>Plan Year Maximum</b>	Per covered individual	\$2,000	No coverage or benefits provided
<b>Orthodontia Benefits</b>	Orthodontic benefits are available for children and adults. Lifetime maximums are per covered individual.	50% to \$2,000 lifetime maximum	50% to \$2,000 lifetime maximum
<b>TMJ Benefits</b>	Plan year maximum of \$1,000 per covered individual Lifetime Maximum of \$5,000 per covered individual Pre-authorization recommended	50%	No coverage or benefits provided

*This is a general summary only. Refer to your Summary Plan Description (SPD) for full details on coverage, exclusions and limitations.*

<b>Open Network Dental Plan—Delta Dental of Washington</b>	<b>Maximums and Limits</b>	<b>Delta Dental PPO Provider</b>	<b>Delta Dental Premier Dentist</b>	<b>Non-Participating Dentist</b>
<b>Group #09034</b>	<b>(Plan Year is January 1 through December 31)</b>			
<b>Plan Year Deductible</b>	Waived on Class I Benefits, Orthodontic Benefits, and Accidental Injury Benefits	\$50 per individual \$150 per family	\$50 per individual \$150 per family	\$50 per individual \$150 per family
<b>Class I Benefits</b>	Diagnostic and Preventive: Exams, cleanings, fluoride (through age 18), X-rays, and sealant  Accidental Injury Treatment	100%	100%	100%
<b>Class II Benefits</b>	Restorative: Fillings, oral surgery, root canals, periodontics	80%	80%	80%
<b>Class III Benefits</b>	Major: Crowns, dentures, bridges, partials, implants, dental night guards (covered at 50% for bruxism every 3 years)	50%	50%	50%
<b>Plan Year Maximum</b>	Per covered individual	\$2,000	\$2,000	\$2,000
<b>Orthodontia Benefits</b>	Orthodontic benefits are available for children and adults. Lifetime maximums are per covered individual.	50% to \$2,000 lifetime maximum	50% to \$2,000 lifetime maximum	50% to \$2,000 lifetime maximum
<b>TMJ Benefits</b>	Plan year maximum of \$1,000 per covered individual Lifetime Maximum of \$5,000 per covered individual Pre-authorization recommended	50%	50%	50%

*This is a general summary only. Refer to your Summary Plan Description (SPD) for full details on coverage, exclusions and limitations.*

Vision—Vision Service Plan		Maximums and Limits	All Plans	
Group #12122822		(Plan Year is January 1 through December 31)	Participating Providers and Affiliate Providers*	Non-Participating Providers
<b>Vision Exam</b>		One exam allowed per plan year.	100% after \$5 copay	Reimbursed up to \$45 after \$5 copay
<b>Lenses</b>	<b>Single Vision</b>	One pair every plan year; One \$25 copay applies to both lenses and frames (copay only applied once during the plan year to either lenses or frames but not both); Standard progressive lenses covered in full; Polycarbonate lenses for dependent children covered in full; Contact lenses (elective and medically necessary) in lieu of lenses and frames within the same plan year. Eligibility for Medically Necessary contact lenses is determined by the VSP doctor at the time of service.	100% after \$25 copay	Reimbursed up to \$30/pair after \$25 copay
	<b>Lined Bifocal</b>		100% after \$25 copay	Reimbursed up to \$50/pair after \$25 copay
	<b>Lined Trifocal</b>		100% after \$25 copay	Reimbursed up to \$65/pair after \$25 copay
	<b>Elective Contact Lenses</b>		100%, up to \$200 for contacts; Separate copay of up to \$60 for contact lens exam (fitting and evaluation)	Reimbursed up to \$105/pair (no copay)
	<b>Medically Necessary Contacts</b>		100% after \$25 copay	Reimbursed up to \$210/pair after \$25 copay
<b>Frames</b>		Once every plan year.	100% up to \$200 after copay (if you choose a frame valued at more than the plan allowance, you will receive a 20% discount on the amount over the allowance). \$110 allowance at Costco/Walmart/Sam's Club.	Reimbursed up to \$70 after \$25 copay

\* Coverage with a retail chain affiliate may be different. Once your benefit is effective; visit [t-mobile.vspforme.com](http://t-mobile.vspforme.com) for details. Discounts are not available at Costco/Walmart/Sam's Club, Costco/Walmart/Sam's Club pricing applies. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Health Plan Eligibility—All Plans	
<b>Eligibility for Medical, Dental and Vision</b>	<p>All Regular Full-Time Employees and Regular Part-Time Employees scheduled to work 20 hours or more per week are eligible to participate in the Plan. Employees must work in the United States or be a T-Mobile Employee on an approved foreign assignment. Refer to your Employee Handbook for Employee status definitions. Employee benefits are effective on the first day of the month following 30 days of employment.</p> <p>Employee benefits terminate at the end of the month.</p> <p>Addition of a spouse or domestic partner to the plan begins after date of marriage or domestic partnership certification. Addition of child begins on date of birth, date of placement for adoption or date of court appointed legal guardianship. <b>Newborns, newly adopted children and children gained through legal guardianship must be enrolled within the first 60 days from date of birth, date of placement for adoption or date of court appointed legal guardianship.</b></p> <p>Dependent benefits terminate on the last day of the month that the dependent ceases to be eligible by status or age.</p> <p>“Dependent” includes the following:</p> <ul style="list-style-type: none"> <li>▪ Legal spouse.</li> <li>▪ Same-sex or opposite sex domestic partner including common law spouses.</li> <li>▪ You or your spouse’s/domestic partner’s child up to age 26.</li> <li>▪ Unmarried children, age 26 and over, who are fully handicapped prior to the maximum age for eligibility.</li> <li>▪ Any other child who depends primarily on the employee for support, including the employee’s biological child, stepchild (who resides with the employee), legally adopted child, or any other dependent acquired other than at the time of the birth due to court order or decree; or an employee’s grandchild who is covered as a dependent upon proof of legal guardianship.</li> </ul>

Qualifying “Change in Status” Events	
	<p>Once your election is made, you cannot change or cancel it during the plan year unless certain events occur. Any changes to your health insurance elections must be made within 31-days of the qualifying event. Changes relating to birth, adoption or eligibility related to Medicaid or Children’s Health Insurance Program (CHIP) coverage must be made within 60 days of the event. Any requested change in election must be consistent with the need created by the qualifying change in status event. Examples of qualifying changes in status events include:</p> <ul style="list-style-type: none"> <li>▪ Marriage, divorce, legal separation or annulment</li> <li>▪ Death of employee’s spouse or dependent</li> <li>▪ Birth, adoption or placement for adoption, or legal guardianship of a child</li> <li>▪ Change in the employee’s or employee’s spouse employment status impacting eligibility for health coverage.</li> <li>▪ Change in worksite or residence</li> <li>▪ Adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify under the plan</li> <li>▪ Significant change in the employee’s spouse’s health coverage</li> <li>▪ Leave of absence under the Family and Medical Leave Act</li> <li>▪ Entitlement to Medicare or Medicaid of the employee, the employee’s spouse or dependent</li> <li>▪ Spouse becomes, or ceases to be, a tax dependent</li> <li>▪ Dependent child turns age 13 and associated dependent care costs are no longer considered eligible expenses under the Dependent Care Flexible Spending Account.</li> <li>▪ Change in Dependent Care providers</li> <li>▪ Change in cost charged by dependent care provider</li> <li>▪ Your hours of service are reduced, to average less than 30 hours of service per week, but you still remain eligible for coverage.</li> <li>▪ You would like to cease coverage under T-Mobile’s health plan for yourself and any related individuals and purchase coverage through an Exchange.</li> </ul>

<b>Flexible Benefit Plans</b>	
<b>Health Care Spending Account</b>	
<b>Contributions</b>	<ul style="list-style-type: none"> <li>▪ Maximum of \$3,300 as pretax contribution per plan year.</li> <li>▪ If you have unused Health Care Spending Account dollars at the end of the plan year, up to \$660 will carry over to the next year. Amounts above \$660 will be forfeited.</li> <li>▪ May not make changes during plan year, EXCEPT for certain qualifying events (see list above).</li> <li>▪ Must re-enroll each plan year.</li> </ul>
<b>Reimbursement</b>	<p>Any unreimbursed health care expenses, such as:</p> <ul style="list-style-type: none"> <li>▪ Medical, Dental, and Vision co-pays, co-insurance, and deductibles;</li> <li>▪ Over-the-counter drugs with a prescription or letter of medical necessity;</li> <li>▪ Any other medical, dental, or vision expenses not covered by our plan that would otherwise be considered deductible for tax purposes by the IRS;</li> <li>▪ For an expanded list of eligible expenses, go to <a href="http://www.t-mobilebenefits.com">www.t-mobilebenefits.com</a></li> </ul>
<b>Limitations</b>	<p>Expenses not eligible for reimbursement include:</p> <ul style="list-style-type: none"> <li>▪ Over-the-counter vitamins or dietary supplements not prescribed by your doctor;</li> <li>▪ Personal care products;</li> <li>▪ Insurance premiums;</li> <li>▪ Cosmetic Surgery.</li> </ul>
<b>Dependent Care Spending Account</b>	
<b>Contributions</b>	<ul style="list-style-type: none"> <li>▪ Maximum of \$7,500 as pretax contribution per plan year.</li> <li>▪ May not make changes during plan year, EXCEPT for certain qualifying events (see list above).</li> <li>▪ Must re-enroll each plan year.</li> </ul>
<b>Reimbursement</b>	<p>Expenses for dependent care and household services incurred, if the expenses are necessary to allow you (and your spouse if you are married) to work or attend school full-time. Special rules apply if your spouse is disabled or a full-time student. Dependent care (child day care or elder care) expenses must be for:</p> <ul style="list-style-type: none"> <li>▪ Dependent child under age 13 for whom you can claim an exemption on your tax return.</li> <li>▪ Dependent or spouse who is physically or mentally incapable of caring for themselves.</li> </ul> <p>Services may be provided inside or outside your home by baby-sitter companions or by eligible dependent care centers. Someone you claim as a dependent on your tax return may not provide services. Daycare for an elderly dependent - the dependent must spend at least eight hours a day in your household (cannot be medical related). For an expanded list of eligible expenses, go to <a href="http://www.t-mobilebenefits.com">www.t-mobilebenefits.com</a></p> <p>Employees will not be able to claim dependent care expenses for the period of time they are on a Leave of Absence and their Dependent Care Flexible Spending Account contribution will be suspended. When the employee returns to work their Dependent Care Flexible Spending Account annual contribution will be reinstated and they will pay catch-up contributions from each paycheck.</p>
<b>Limitations</b>	<p>Expenses not eligible for reimbursement include:</p> <ul style="list-style-type: none"> <li>▪ Food, clothing or entertainment for a dependent.</li> <li>▪ Expenses for overnight camps, or educational expenses for children in Kindergarten or older (before and after-school care expenses are eligible).</li> <li>▪ Nursing home expenses.</li> </ul>
<b>Childcare Subsidy Program</b>	
	<ul style="list-style-type: none"> <li>▪ Eligible employees can receive up to \$250 per month to help with childcare costs.</li> <li>▪ In order to be eligible, an employee must have a gross annual base pay of \$99,000 or less and be benefits eligible.</li> <li>▪ Enrollment in the subsidy program can only occur at initial eligibility, annual enrollment or due to a qualifying mid-year status change.</li> <li>▪ The childcare subsidy is a per household/family benefit.</li> <li>▪ Employee will not receive Childcare Subsidy while on Leave of Absence. Upon return from Leave of Absence any missed Subsidy contributions will be funded on the first of the next month.</li> <li>▪ For more details, visit <a href="http://t-mobilebenefits.com">t-mobilebenefits.com</a> or call the T-Mobile Benefits Center at 1-855-TMO-BENS (855-866-2367).</li> </ul>

Carrier/Vendor Information		
<b>Medical Plan – HMSA</b> Plan #94833	<b>Claims address:</b> HMSA Attn: Claims Department P.O. Box 860 Honolulu, HI 96808  <b>Customer service phone number:</b> 1-800-776-4672 or 1-808-948-6111	<b>Web site info:</b> <a href="http://hmsa.com">http://hmsa.com</a>
<b>LiveMagenta (including EAP)</b>	(855) 780-5958	<a href="https://livemagenta.com/">https://livemagenta.com/</a>
<b>Dental Plan Delta Dental of Washington Group #09037 &amp; #09034</b>	<b>Claims address:</b> Delta Dental of Washington P.O. Box 75983 Seattle, WA 98175-0983	<b>Member services phone number:</b> (800) 238-3107  <b>Web site info:</b> <a href="http://www.deltadentalwa.com">www.deltadentalwa.com</a> (select “subscribers” area)
<b>Vision Plan Vision Service Plan Group #12122822</b>	<b>Claims address:</b> Vision Service Plan P.O. Box 495933 Cincinnati, OH 45249	<b>Member services phone number:</b> (800) 877-7195  <b>Web site info:</b> <a href="http://t-mobile.vspforme.com">t-mobile.vspforme.com</a>
<b>Flexible Spending Account Benefit Plan Your Spending Account</b>	<b>Claims address:</b> Y.S.A. P.O. Box 785040 Orlando, FL 32878-5040	<b>Toll-free Customer Service phone number:</b> (855) TMO-BENS <b>Outside of US:</b> (847) 883-1150
		<b>Toll-free Claims fax number:</b> (888) 211-9900 <b>Outside of US:</b> (847) 554-1409
		<b>Web site info:</b> <a href="http://www.t-mobilebenefits.com">www.t-mobilebenefits.com</a>

<b>Short Term Disability</b>	<b>Plan Provisions</b>
<b>Broadspire-Plan #022083</b>	
<b>Eligibility</b>	1st day of the month coinciding with or following 180 days of continuous active employment. All Active Employees scheduled to work a minimum full time or part time, excluding temporary, leased or seasonal employees.
<b>Definition of Earnings</b>	Weekly Rate of Pay means your Pre-disability Earnings divided by 52. Disability Earnings does not include anything other than the amounts listed above. So, it doesn't include corporate bonus, tips, tokens, overtime/double-time pay, shift differential pay, stock options, prizes, gifts, stock bonuses, any other fringe benefits, your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other compensation.
<b>Elimination Period</b>	7 days
<b>Benefit Schedule</b>	85% of your pre-disability earnings for weeks 2 through 26
<b>Minimum/Maximum Weekly Benefit</b>	No Minimum / No Maximum, reduced by deductible income
<b>Definition of Disability</b>	Total Disability or Disabled and Working.
<b>Maximum Period of Benefits</b>	Total of 26 weeks. First week is a waiting period, weeks 2 to 26 are paid.
<b>Integration with Other Income</b>	Direct offset for other sources of income such as state disability benefits, third party payments, retirement benefits, etc.
<b>Exclusions</b>	Benefits do not apply to: work related disabilities, intentionally self-inflicted injuries, any act of war, committing or attempting to commit an assault or felony, if caused or contributed to by your being engaged in an illegal occupation, sustained as a result of doing any work for pay or profit for another employer, that are related to falsified information submitted regarding your disability, are for a cosmetic procedure and if you are receiving or are eligible for benefits of disability under a prior disability plan. You must be under the regular care of a physician in order for this plan to pay benefits for any disability.

<b>Long Term Disability</b>	<b>Plan Provisions</b>
<b>The Hartford—Plan #GLT-402610</b>	
<b>Eligibility</b>	1st of month coinciding with or following 180 days of continuous active employment. Full-Time employees (minimum of 30 hours a week). Part-Time employees (minimum of 20 hours a week).
<b>Definition of Earnings</b>	Monthly benefit looks at pre-disability earnings and multiply by the benefit percentage. Pre-Disability Earnings does not include anything other than the amounts listed above. So, it doesn't include corporate bonus, tips, tokens, overtime/double-time pay, shift differential pay, stock options, prizes, gifts, stock bonuses, any other fringe benefits, your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other compensation
<b>Elimination Period</b>	180 days
<b>Benefit Schedule</b>	50% of pay for Full-Time employees and for Part-Time employees. There will be a buy-up option to elect 60% or 66 2/3% of pay
<b>Minimum/Maximum Monthly Benefit</b>	Minimum: \$100 per month / Maximum: \$20,000 per month
<b>Definition of Disability</b>	Due to injury, illness or pregnancy, you are unable to perform the material duties of your own occupation and you have a 20% or more earnings loss. After 24 months of benefit payments, you are disabled if it is determined that due to injury, illness or pregnancy; you are unable to perform the material duties of any gainful occupation.
<b>Maximum Benefit Duration</b>	Social Security normal retirement age
<b>Integration with Other Income</b>	Direct offset for other income sources such as social security, workers compensation, state disability benefits etc.
<b>Benefits while Working</b>	No offset for earnings during the first 12 months of working until earnings plus the gross LTD benefit exceeds 100% of indexed pre-disability income. Partial offset for earnings after 12 months.
<b>Rehabilitation Requirements</b>	Mandatory. Employee must participate, unless the disability prevents the employee from participating, or benefits terminate.
<b>Limited Conditions</b>	Some conditions are limited to a 24-month lifetime benefit limit. Please review your plan booklet for details.

<b>Long Term Disability</b>	<b>Plan Provisions</b>
<b>The Hartford—Plan #GLT-402610</b>	
<b>Pre-Existing Condition Waiting Period</b>	<p>Full-Time Employees—No coverage for a condition for which you were treated or diagnosed within 3 months of your coverage effective date until insured for 12 months. Preexist waiting period may not apply if you have been treatment free for 3 months while covered under this Policy.</p> <p>Part-Time Employees—No coverage for a condition for which you were treated or diagnosed within 6 months of your coverage effective date until insured for 24 months. Preexist waiting period may not apply if you have been treatment free for 6 months while covered under this Policy.</p>

<b>Basic Life and AD&amp;D</b>	<b>Plan Provisions</b>
<b>The Hartford—Plan #GL-402610 and ADD-S07649</b>	
<b>Eligibility</b>	Day 1 of employment. Full-Time employees (minimum of 30 hours a week). Part-Time employees (minimum of 20 hours a week).
<b>Benefit</b>	1.5 times your annual base pay plus annualized average commissions received during the preceding 12-month period, rounded to the next higher \$1,000. Bonuses and overtime excluded.
<b>Maximum</b>	Maximum of \$1,000,000 of coverage.
<b>Guarantee Issue</b>	An employee is automatically enrolled for Basic Life and AD&D. All coverage is Guarantee Issue.

<b>Voluntary Life</b>	<b>Plan Provisions</b>
<b>The Hartford—Plan #GL-402610</b>	
<b>Eligibility</b>	1st of month coinciding with or following 30 days of continuous employment. Full-Time employees (minimum of 30 hours a week). Part-Time employees (minimum of 20 hours a week).
<b>Benefit</b>	Eight options to choose from: One, two, three, four, five, six, seven or eight times your annual base pay plus annualized average commissions received during the preceding 12-month period, rounded to the next higher \$1,000.
<b>Maximum</b>	Maximum of \$2,000,000 of coverage, combined maximum between Basic and Optional Life of \$3,000,000.
<b>Guarantee Issue</b>	Up to the lesser of three times pay or \$750,000 is guarantee issue at initial eligibility. Elections over this amount will require proof of good health. An employee can also enroll or increase coverage within 31 days of a qualified Life event, subject to the guarantee issue amount of up to the lesser of three times pay or \$750,000. At annual enrollment, one level increase is allowed up to \$750,000.

<b>Dependent Life</b>	<b>Plan Provisions</b>
<b>The Hartford—Plan #GL-402610</b>	
<b>Eligibility</b>	1st of month coinciding with or following 30 days of continuous employment. Full-Time employees (minimum of 30 hours a week). Part-Time employees (minimum of 20 hours a week).
<b>Benefit</b>	Spouse/Domestic Partner and children coverage may be purchased separately. <ul style="list-style-type: none"> <li>■ Spouse/Domestic Partner: \$10,000, \$25,000, \$50,000, \$75,000, \$100,000, \$150,000, \$200,000 or \$250,000 of coverage</li> <li>■ Dependent child(ren): \$10,000 or \$20,000 of coverage per child</li> </ul>
<b>Maximums and Limitations</b>	Spousal/Domestic Partner coverage is limited to 100% or less of employee's combined basic and voluntary life coverage amount.
<b>Guarantee Issue</b>	Spousal/Domestic Partner coverage up to \$50,000 is guarantee issue. There are no guarantee issue requirements for children coverage. When both parents are employees, they can both cover the same child(ren).

Voluntary AD&D	Plan Provisions
The Hartford—Plan #S07649	
Eligibility	1st of month coinciding with or following 30 days of continuous employment. Full-Time employees (minimum of 30 hours a week). Part-Time employees (minimum of 20 hours a week).
Benefit	Employee only or Employee plus Family Eight options to choose from: One, two, three, four, five, six, seven or eight times your annual base pay plus annualized average commission received during the preceding 12-month period, rounded to the next higher \$1,000 <ul style="list-style-type: none"> <li>▪ EE: 100% benefit</li> <li>▪ Spouse/DP only: 60% benefit</li> <li>▪ Child(ren) only: 25% benefit</li> <li>▪ Spouse/DP and Child(ren): 50% Spouse/DP and 25% Child(ren)</li> </ul>
Maximums and Limitations	<ul style="list-style-type: none"> <li>▪ Employee Max: \$2,000,000</li> <li>▪ Spouse/DP Max: \$900,000 (sp only) / \$750,000 with Child(ren)</li> <li>▪ Child(ren) Max: \$100,000</li> </ul>
Guarantee Issue	All coverage amounts are guaranteed

Carrier/Vendor Information	Life, AD&D and LTD Plans	
The Hartford	<b>General Inquiries:</b> (855) 899-2973	<b>Web site info:</b> <a href="https://mybenefits.thehartford.com">https://mybenefits.thehartford.com</a>
	<b>Mailing address:</b>  <b>LTD:</b> The Hartford PO Box 14302 Lexington, KY 40512-4302  <b>Life and Accidental Death and Dismemberment (AD&amp;D):</b> The Hartford P.O. Box 14299 Lexington, KY 40512-4299	
Broadspire	<b>Mailing address:</b> P.O. Box 14773 Lexington, KY 40512	

<b>Business Travel Accident</b>	<b>Plan Provisions</b>
<b>The Hartford—Plan #10-GTA-101903</b>	
<b>Policy Term</b>	1/1/2026 – 12/31/2026
<b>Eligibility</b>	Day 1 of employment. All active, Full-time and Part-time Employees of the Policyholder domiciled in the US. and Puerto Rico  Full-time employee means a person who: a) is regularly employed by the Policyholder in the course of their business; and b) works at least 20 hours per work week.  Truck Drivers, chauffeurs and delivery persons are not Eligible Persons regardless of whether they otherwise qualify under one or more of the above Class Descriptions.
<b>AD&amp;D Principal Sum</b>	\$500,000 per person per accident.
<b>Coverage Area</b>	Worldwide Travel Business trip coverage 24-hour coverage War risk hazard  Covered loss within 365 days of accident
<b>Travel Requirements</b>	Business Trip means a bona fide trip: a) while on assignment or at the direction of the Policyholder for the purpose of furthering the business of the Policyholder; b) which begins when a person leaves his or her residence or place of regular employment, whichever last occurs, for the purpose of beginning the trip; c) which ends when he or she returns to his or her residence or place of regular employment, whichever first occurs; and d) excluding travel to and from work, bona fide leaves of absence and vacations.
<b>Additional Benefits Provided</b>	Extraordinary/alternative commuting to and from work, Exposure and disappearance, Seat belt benefit, Therapy counseling, Rehabilitation expense, Hijacking benefit, Coma benefit, Standard accidental death, dismemberment and paralysis benefits.

<b>Business Travel Medical</b>	<b>Plan Provisions</b>
<b>The Hartford—Plan #10-GTA-101903</b>	
<b>Policy Term</b>	1/1/2026 – 12/31/2026
<b>Eligibility</b>	Active full-time employees and guests of T-Mobile USA, Inc. traveling outside their country of permanent residence or assignment on the business of T-Mobile USA, Inc.*  Up to 5 dependents included  *Includes coverage for U.S. citizens traveling to U.S. territories
<b>Covered Activities</b>	Covered Services are received by a Subscriber who is traveling outside his or her home country primarily for the purpose of business, as authorized by the Enrolling Group. Coverage outside the US only. Includes sojourn travel up to 7 days
<b>Deductible</b>	\$0
<b>Coinsurance</b>	100%
<b>Calendar Year Maximum</b>	\$250,000
<b>Additional Benefits Provided</b>	Prescription drug, inpatient hospital services, ambulance services, emergency dental, emergency medical evacuation/repatriation of remains

Carrier Information	
The Hartford	<p align="center"><b>Business Travel Accident</b></p> <p align="center">P.O. Box 14299  Lexington, KY 40512-4299  Fax to: 1-866-954-2621  E-Mail to: gbclaimcslife@thehartford.com  Phone: 1-888-563-1124</p>
The Hartford	<p align="center"><b>Business Travel Medical</b></p> <p align="center">P.O. Box 14299  Lexington, KY 40512-4299  Fax to: 1-866-954-2621  E-Mail to: gbclaimcslife@thehartford.com  Phone: 1-888-563-1124</p>