

Health and Welfare Plans Combined Summary



January 1, 2026—December 31, 2026

T-Mobile USA, Inc. 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 company's Summary Plan Description.

<i>Premera Blue Cross / UHC / Surest</i>	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
<i>Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)</i>	No out-of-network benefits are available.	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK¹</i>	<i>IN-NETWORK</i>	<i>OUT-OF-NETWORK¹</i>	No out-of-network benefits are available.
Plan Year Deductible <ul style="list-style-type: none"> Family deductible is accumulative, for those with enrolled dependents. No carryover of deductibles. Any amount you pay for eligible medical and prescription drug expenses before your health plan begins to share in the cost of covered services. (Copayments; Expenses over the Eligible Expenses²; and/or Expenses associated with non-covered services do not apply to the deductible) 	No deductible	Benefits with copayments are not subject to deductibles with the exception of the Emergency Care benefit. The deductible is combined between In and Out-of-Network. \$2,250 individual \$4,500 family		The deductible is combined between In and Out-of-Network. The family deductible must be met before the plan coinsurance applies for those with enrolled dependents. \$2,250 individual \$4,500 family		Benefits with copayments are not subject to deductibles, with the exception of the Emergency Care benefit. \$750 individual \$1,500 family
Copayments <ul style="list-style-type: none"> Copayments apply toward the Plan Year Maximum. The PCP copay applies to family practitioners, general practitioners, pediatricians and internists. Copayments are not applicable for Out-of-Area Plans 	PCP—\$25 - \$130 office visit Specialist—\$25 - \$130 office visit \$50 urgent care center \$600 emergency room	PCP—\$35 office visit Specialist—\$50 office visit \$50 urgent care center \$200 emergency room	Not applicable for office visit and urgent care center \$200 emergency room	Not applicable	Not applicable	PCP—\$20 office visit Specialist—\$30 office visit \$30 urgent care center \$200 emergency room
Coinsurance <ul style="list-style-type: none"> Medical coinsurance applies to Plan Year Maximum. 	No coinsurance	100% after applicable copayment for most office visits 80% after deductible for most other services	60% after deductible	80% after deductible for most services	60% after deductible	100% after applicable copayment for most office visits 80% after deductible for most other services
Plan Year Maximum (Excluding Deductibles) The Maximum excludes the following, which continue even after the maximum is met: <ul style="list-style-type: none"> Deductibles Amounts above Eligible Expenses/Allowed Amounts 	\$6,500 individual \$13,000 family	The Plan Year Maximum is combined between In and Out-of-Network. \$2,000 individual \$4,000 family		The Plan Year Maximum is combined between In and Out-of-Network. \$2,000 individual \$4,000 family		\$3,000 individual \$6,000 family

¹ For those enrolled in the out-of-area plans, coverage is as outlined in the columns below. Any differences specific to the out-of-area plans will be noted in a bullet in the left-hand column.

² For Premera, out-of-network charges are based on the Allowed Amount.

Premera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan	
Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	No out-of-network benefits are available.	
<ul style="list-style-type: none"> Prior authorization penalty (see "Prior Authorization Requirement") 							
Total Out-of-Pocket Maximum (Includes Deductibles) Covered medical and pharmacy expenses you pay out of pocket associated with a deductible, coinsurance, or copay, – not reimbursed to you by your insurance carrier or other program such as a pharma sponsored coupon. Note that the following may still apply after you meet your Total Out-of-Pocket Maximum: <ul style="list-style-type: none"> Amount above R&C Prior authorization (see "Prior Authorization Requirement") 	\$6,500 individual \$13,000 family	The Total Out-of-Pocket Maximum is combined between In and Out-of-Network. \$4,250 individual \$8,500 family		The Total Out-of-Pocket Maximum is combined between In and Out-of-Network. The family Total Out-of-Pocket Maximum must be met before the plan covers 100%, for those with enrolled dependents. \$4,250 individual \$8,500 family		\$3,750 individual \$7,500 family	
Lifetime Maximum Benefit	Limit does not apply.						
Coordination of Benefits	Regular coordination of benefits (come out whole approach). Birthday rule applies.						
Pre-existing Conditions	No pre-existing condition limitation.						
Prior Authorization Requirement Services requiring prior authorization include:	Check with Plan	Check with Plan		Check with Plan		Check with Plan	
<u>For UHC & Surest Plans – in network providers are responsible for obtaining prior authorization on your behalf, some exceptions apply – please check with Plan for additional details on requirements:</u> <ul style="list-style-type: none"> All inpatient admissions (except maternity) including acute hospital, rehabilitation facilities, skilled nursing facilities and hospice (if an Emergency admission to a Non-Network provider occurs, the Employee should call within two business days). All home-based services, including nursing services, respiratory, speech, physical and occupational therapies, IV infusion services and hospice. Durable Medical Equipment (greater than \$1,000). Prosthetic Devices (if device costs more than \$1,000). Reconstructive procedures, both inpatient and outpatient procedures; including but not limited to the following parts of the body: abdomen; back; ear, nose, and throat; pelvic; foot; heart; knee/hip; rectum. 				<ul style="list-style-type: none"> Maternity Services admissions that exceed the federally mandated length of stay of 48 hours for vaginal or 96 hours for cesarean delivery. Accidental dental services. Organ and tissue transplant services (including evaluations). End Stage Renal Disease services. Blepharoplasty (upper eye lid surgery). Breast Reconstruction, other than surgery following treatment for cancer (mastectomy). Breast Reduction. Ligation (vein stripping) 			
<u>For Premera Blue Cross Plan – The plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility. Please contact your in-network provider or Premera Customer Service before you receive a service to find out if your service requires prior authorization</u> <ul style="list-style-type: none"> All inpatient admissions (except hospice and maternity) including acute hospital, rehabilitation facilities, skilled nursing facilities (if an Emergency admission to a Non-Network provider occurs, the Employee should call within two business days). Ambulance—Transportation by fixed-wing aircraft (plane). Elective (non-emergent) Air Ambulance Transport Reconstructive and Surgical procedures, both Inpatient and Outpatient. Electric or Motorized wheelchairs and scooters. Genetic testing. 				<ul style="list-style-type: none"> Transplants: complex organ transplants and autologous progenitor cell therapy (stem cell) Maternity Services admissions that exceed the federally mandated length of stay of 48 hours for vaginal or 96 hours for cesarean delivery. Hyperbaric Oxygen Therapy. Lower limb prosthesis. Nonparticipating free standing ambulatory surgical facilities, when referred by a participating provider. Ventricular assist devices. Dental Implants. 			

Premera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	No out-of-network benefits are available.
UHC & Surest Plans Only: Enhanced Personal Health Support	Specially trained nurses assist you in navigating the health care system and ensure you get the care you need. If you have a chronic condition or an upcoming hospitalization, a UnitedHealthcare or Surest nurse will contact you. This is a confidential, voluntary program. The nurses will educate you regarding your condition and work with you and your healthcare provider to ensure that your treatment needs are met.					
Premera Blue Cross Plan Only: Personal Health Support Programs	<p>The plan offers participation in Premera Blue Cross's personal health support services to help members with such things as managing complex medical conditions, a recent surgery, or admission to a hospital. Services include:</p> <ul style="list-style-type: none"> ■ Helping to overcome barriers to health improvement or following providers' treatment plan ■ Coordinating care services including access ■ Helping to understand the health plan's coverage ■ Finding community resources <p>To learn more about the personal health support programs, contact Customer Service at 1-866-358-2300</p>					
Out-of-Area Plan—Passive PPO Network	If a member that is enrolled in the Out-of-Area plan is away from home and seeks services from a UHC/Premera Blue Cross network provider, network discounts will apply. Also, the member will not be responsible for the cost difference between the actual charge and UHC's/Premera's allowed amount.					
Physician and Specialist Office Services						
<ul style="list-style-type: none"> ■ Office visits. ■ Eye and Hearing examination (for diagnosis / treatment of a medical condition only). ■ Covered health services provided by a non-network physician in certain network facilities will apply the same cost sharing (copayment, coinsurance and applicable deductible) as if those services were provided by a network provider; however Eligible Expenses or Allowed Amounts will be determined as described in the SPD. ■ Out-of-Area plans' coverage 80% after deductible. 	PCP—\$25 - \$130 office visit Specialist—\$25 - \$130 office visit	PCP—100% after \$35 copay Specialist—100% after \$50 copay Testing and Treatment 80%, no deductible	60% after deductible	80% after deductible	60% after deductible	PCP—100% after \$20 copay Specialist—100% after \$30 copay Testing and Treatment 80%, no deductible (Naturopaths covered out of network)
Physician Maternity Services <ul style="list-style-type: none"> ■ Global obstetrical care, including physician charges for delivery and all pre- and post-natal care. ■ Pre- / post-routine office visits ■ Physician services (delivery) ■ Licensed nurse midwives, and home births by covered licensed providers are covered ■ Elective abortions covered. Travel & lodging available; see Travel & Lodging section for details ■ Maternity service for dependent daughters is covered. ■ Grandchildren are not covered unless they qualify as 	Prenatal and Postnatal Care is 100%, no copay	Initial Office Visit PCP—100% after \$35 copay Specialist—100% after \$50 copay Routine prenatal office visits are covered at 100% after the first office visit copay. In-office lab / x-ray is also paid at 100% after first office visit copay Global Obstetrical Care 80% after deductible	60% after deductible	80% after deductible	60% after deductible	Initial Office Visit PCP—100% after \$20 copay Specialist—100% after \$30 copay Global Obstetrical Care 80% after deductible

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Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK ¹	IN-NETWORK	OUT-OF-NETWORK ¹	No out-of-network benefits are available.
<p>dependents under the T-Mobile plan definition.</p> <ul style="list-style-type: none"> For hospital delivery, refer to "Inpatient Care" for benefits. For lab work or x-rays billed separately from doctor, refer to "Outpatient Laboratory/X-ray" for benefits. Out-of-Area plans' coverage 80% after deductible. 						
<p>Newborn Care</p> <ul style="list-style-type: none"> If birth mother is covered through T-Mobile plan, newborns will be automatically covered for the first 31 days under their own claim file. This does not mean the newborn is automatically enrolled. To qualify for dependent coverage, all newborns must be enrolled within first 60 days. The newborn will be subject to its own deductible, coinsurance maximum and the other benefit provisions of the HSA plan. Out-of-Area plans' coverage 80% after deductible 	<p>Prenatal and Postnatal Care is 100%, no copay</p> <p>Newborns who remain inpatient after mother's discharge are subject to a \$3,500 Inpatient care copay</p>	<p>Office Visit PCP—100% after \$35 copay Specialist—100% after \$50 copay</p> <p>Inpatient Care 80% after deductible</p> <p>Inpatient well newborn is not subject to deductible</p>	<p>60% after deductible</p> <p>Inpatient well newborn is not subject to deductible</p>	<p>80% after deductible</p> <p>Inpatient well newborn is subject to deductible</p>	<p>60% after deductible</p> <p>Inpatient well newborn is subject to deductible</p>	<p>Office Visit PCP—100% after \$20 copay Specialist—100% after \$30 copay</p> <p>Inpatient Care 80% after deductible</p> <p>Inpatient well newborn is not subject to deductible</p>
<p>Preventive Care</p> <ul style="list-style-type: none"> Well-child care from birth through age 17. No pre-set examination schedule. At physician's discretion. One routine exam allowed each plan year for adults in addition to one well-women exam per plan year. Includes immunizations for children and adults. One prostate exam allowed each plan year, plus associated lab work. One Pap smear per plan year. Routine mammograms allowed once per plan year – schedule set at physician's discretion, not by age. One routine hearing exam per plan year. Colonoscopy cancer screenings at physician's direction 	<p>Office Visit / Prostate Exam PCP and Specialist: 100%, no copay</p> <p>Annual Flu Shot 100%, no copay</p> <p>Lab and X-ray 100%, no copay</p> <p>Routine Mammogram 100%, no copay</p> <p>Breast Pumps 100%, no copay</p> <p>Routine Colonoscopy 100%, no copay</p>	<p>Office Visit / Prostate Exam PCP and Specialist: 100%, no deductible or copay</p> <p>Annual Flu Shot 100%, no deductible or copay</p> <p>Lab and X-ray 100%, no deductible or copay</p> <p>Routine Mammogram 100%, no deductible or copay</p> <p>Breast Pumps 100%, no deductible or copay</p> <p>Routine Colonoscopy 100%, no deductible or copay</p>	<p>Office Visit / Prostate Exam PCP and Specialist: 100%, no deductible or copay</p> <p>Annual Flu Shot 100%, no deductible or copay</p> <p>Lab and X-ray 100%, no deductible or copay</p> <p>Routine Mammogram 100%, no deductible or copay</p> <p>Breast Pumps 100%, no deductible or copay</p> <p>Routine Colonoscopy 100%, no deductible or copay</p>	<p>Office Visit / Prostate Exam PCP and Specialist: 100%, no deductible</p> <p>Annual Flu Shot 100%, no deductible</p> <p>Lab and X-ray 100%, no deductible</p> <p>Routine Mammogram 100%, no deductible</p> <p>Breast Pumps 100%, no deductible</p> <p>Routine Colonoscopy 100%, no deductible or copay</p>	<p>Office Visit / Prostate Exam PCP and Specialist: 100%, no deductible</p> <p>Annual Flu Shot 100%, no deductible</p> <p>Lab and X-ray 100%, no deductible</p> <p>Routine Mammogram 100%, no deductible</p> <p>Breast Pumps 100%, no deductible</p> <p>Routine Colonoscopy 100%, no deductible or copay</p>	<p>Office Visit / Prostate Exam PCP and Specialist: 100%, no deductible or copay</p> <p>Annual Flu Shot 100%, no deductible or copay</p> <p>Lab and X-ray 100%, no deductible or copay</p> <p>Routine Mammogram 100%, no deductible or copay</p> <p>Breast Pumps 100%, no deductible or copay</p> <p>Routine Colonoscopy 100%, no deductible or copay</p>

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Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	<i>No out-of-network benefits are available.</i>	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	<i>No out-of-network benefits are available.</i>
Prescription Drug Coverage						
<ul style="list-style-type: none"> ▪ Rx coverage provided by CVS ▪ Includes coverage for oral contraceptives, Depo-Provera and Norplant. ▪ Retail—Limited to a 30-day or 90-day supply ▪ Mail Order—Limited to a 90-day supply. ▪ Drugs for erectile dysfunction and hair loss are not covered. ▪ Smoking cessation medications are covered; copays are waived for prescription drugs related to smoking cessation. ▪ Tier 2 medications for blood pressure, cholesterol, diabetic oral medication and supplies are covered subject to a \$15 copay (retail); \$30 copay (mail order) except for HSA plans. ▪ Tier 1 = Your Lowest Cost Option. ▪ Tier 2 = Your Mid-Range Cost Option. ▪ Tier 3 = Your Highest Cost Option. ▪ You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible. 	<p style="text-align: center;">Retail (30 days)</p> <p>Tier 1 (Generic): \$ 10 copay Tier 2 (Preferred): \$75 copay Tier 3 (Non-Preferred): \$200 copay Specialty: \$0 copay if enrolled in Prudent Rx; 30% coinsurance if not enrolled in Prudent Rx; For non-Prudent Rx specialty drug, \$200 copay</p> <p style="text-align: center;">Weight Loss Medications (anti-obesity & anorexiant):</p> <p>\$55 copay maximum</p> <p style="text-align: center;">Mail Order / Retail (90 days)</p> <p>Tier 1 (Generic): \$20 copay Tier 2 (Preferred): \$150 copay Tier 3 (Non-Preferred): \$400 copay</p>	<p style="text-align: center;">Retail (30 days)</p> <p>Tier 1 (Generic): 10% (\$5 copay minimum / \$20 copay maximum) Tier 2 (Preferred): 20% (\$25 copay minimum / \$55 copay maximum) Tier 3 (Non-Preferred): 30% (\$45 copay minimum / \$80 copay maximum) Tier 4 (Specialty): \$0 copay if enrolled in Prudent Rx; 30% coinsurance if not enrolled in Prudent Rx; For non-Prudent Rx specialty drug, copay capped at \$80 max</p> <p style="text-align: center;">Weight Loss Medications (anti-obesity & anorexiant):</p> <p>\$55 copay maximum</p> <p style="text-align: center;">Mail Order / Retail (90 days)</p> <p>Tier 1 (Generic): 10% (\$10 copay minimum / \$40 copay maximum) Tier 2 (Preferred): 20% (\$50 copay minimum / \$110 copay maximum) Tier 3 (Non-Preferred): 30% (\$90 copay minimum / \$160 copay maximum)</p>	<p style="text-align: center;">Retail and Mail Order</p> <p>Not covered</p>	<p style="text-align: center;">Retail (30 days)</p> <p>All tiers: 80% after deductible</p> <p style="text-align: center;">Weight Loss Medications (anti-obesity & anorexiant):</p> <p>Plan pays 80% after deductible</p> <p style="text-align: center;">Mail Order / Retail (90 days)</p> <p>All tiers: 80% after deductible</p>	<p style="text-align: center;">Retail and Mail Order</p> <p>Not covered</p>	<p style="text-align: center;">Retail (30 days)</p> <p>Tier 1 (Generic): \$ 10 copay Tier 2 (Preferred): \$35 copay Tier 3 (Non-Preferred): \$60 copay Specialty: \$0 copay if enrolled in Prudent Rx; 30% coinsurance if not enrolled in Prudent Rx; For non-Prudent Rx specialty drug, \$60 copay</p> <p style="text-align: center;">Weight Loss Medications (anti-obesity & anorexiant):</p> <p>\$55 copay maximum</p> <p style="text-align: center;">Mail Order / Retail (90 days)</p> <p>Tier 1 (Generic): \$20 copay Tier 2 (Preferred): \$70 copay Tier 3 (Non-Preferred): \$120 copay</p>
Hospital Services						
<p>Emergency Care</p> <ul style="list-style-type: none"> ▪ Benefits paid as in-network, regardless of facility. ▪ If you are admitted as an inpatient to a hospital directly from the emergency room, you will not have to pay this copay, coinsurance and/or deductible. The benefits for an inpatient stay in a hospital will apply instead. ▪ Eligible Expenses or Allowed Amounts for emergency health services provided by a non- 	<p>\$600 copay (copay is waived if admitted).</p>	<p>80% after \$200 copay and deductible (copay is waived if admitted).</p>	<p>80% after \$200 copay and deductible (copay is waived if admitted).</p>	<p>80% after deductible</p>	<p>80% after deductible</p>	<p>80% after \$200 copay and deductible (copay is waived if admitted).</p>

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Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	No out-of-network benefits are available.
network provider will be determined as described in the medical administrators' section of the SPD. <ul style="list-style-type: none"> Out-of-Area plans' coverage 80% after deductible 						
Inpatient Care <ul style="list-style-type: none"> Includes semi-private room and board, and physician and ancillary services Inpatient physical therapy, radiation therapy, chemotherapy, hemodialysis treatment. Out-of-Area plans: prior authorization required for confinement, extensions, and surgery. 	\$3,500 copay	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement and surgery.	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement and surgery.	80% after deductible
Birthing Centers <ul style="list-style-type: none"> Includes semi-private room and board and ancillary services. Out-of-Area plans: prior authorization required for confinement, extensions, and surgery 	Delivery is \$1,500 - \$3,500	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement and surgery.	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement and surgery.	80% after deductible
Mental Health/Substance Abuse Benefits						
<ul style="list-style-type: none"> LiveMagenta Employee Assistance Program (EAP)—Up to ten EAP visits for each covered member provided at no cost per concern per plan year. 						
Inpatient Mental Health <ul style="list-style-type: none"> Out-of-Area plan: prior authorization required for confinement and extensions. 	\$3,500 copay	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement.	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement.	80% after deductible
Outpatient Mental Health <ul style="list-style-type: none"> Out-of-Area plans' coverage 80% after deductible. 	\$25 copay for office visit	100% after \$35 copay	Office visit: 100% after \$35 copay Outpatient: 60% after deductible	80% after deductible	60% after deductible	100% after \$20 copay
Inpatient Substance Abuse <ul style="list-style-type: none"> Out-of-Area plan: prior authorization required for confinement and extensions. 	\$3,500 copay	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement.	80% after deductible	60% after deductible. Prior authorization required for confinement, extension of planned confinement.	80% after deductible
Virtual Behavioral Health Therapy and Coaching (AbleTo) UHC Only: Services must be received by a Designated Network Provider.	\$25 copay for office visit	100%	Not covered	100% after you meet the annual deductible; benefits for the initial consultation will be paid at 100%	Not covered	100%
Outpatient Substance Abuse <ul style="list-style-type: none"> Out-of-Area plans' coverage 80% after deductible. 	\$25 copay for office visit \$170 copay for outpatient Alcohol and Drug Treatment Program	100% after \$35 copay	Office visit: 100% after \$35 copay Outpatient: 60% after deductible	80% after deductible	60% after deductible	100% after \$20 copay

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Partial Hospitalization <ul style="list-style-type: none"> Out-of-Area plans' coverage 80% after deductible 	\$170 copay	80%, no deductible	60%, no deductible	80% after deductible	60% after deductible	80%, no deductible
Intensive Outpatient Care <ul style="list-style-type: none"> Out-of-Area plans' coverage 80% after deductible. 	\$170 copay	80%, no deductible	60%, no deductible	80% after deductible	60% after deductible	80%, no deductible
All Other Covered Services (in alphabetical order)						
Acupuncture <ul style="list-style-type: none"> Limited to 30 visits each plan year. Out-of-Area HRA coverage 100% after deductible; 	\$60 copay	100% after \$50 copay	100% after \$50 copay	80% after deductible	80% after deductible	100% after \$30 copay (out-of-network providers are covered)
Allergy, Testing, and Treatment <ul style="list-style-type: none"> Coverage for diagnosis and treatment in a doctor's office. 	\$0 copay	Office Visit PCP: 100% after \$35 copay Specialist: 100% after \$50 copay Allergy Testing and Treatment 80%, no deductible	Office Visit PCP and Specialist: 60% after deductible Allergy Testing and Treatment 60% after deductible	Office Visit PCP and Specialist: 80% after deductible Allergy Testing and Treatment 80% after deductible	Office Visit PCP and Specialist: 60% after deductible Allergy Testing and Treatment 60% after deductible	Office Visit PCP: 100% after \$20 copay Specialist: 100% after \$30 copay Allergy Testing and Treatment 80%, no deductible
Ambulance (including Air Ambulance) <ul style="list-style-type: none"> For life threatening conditions. For situations in which the patient would be endangered if this benefit was not utilized. Eligible Expenses or Allowed Amounts for Air Ambulance transport provided by a non-Network provider will be determined as described in the medical administrators' section of this SPD 	\$400 copay for both emergency and non-emergency	Emergency: 100%, no deductible Non-Emergency: 80% after deductible		Emergency: 100% after deductible Non-Emergency: 80% after deductible		Emergency: 100%, no deductible Non-Emergency: 80% after deductible
Chiropractic <ul style="list-style-type: none"> Limited to 30 visits each plan year. Out-of-Area coverage 100% after deductible 	\$30 copay	100% after \$50 copay	100% after \$50 copay	80% after deductible	80% after deductible	100% after \$30 copay
Colonoscopy <ul style="list-style-type: none"> Due to medical diagnosis 	\$0 copay	100 %, no deductible		100% after deductible		100%, no deductible or copay
Disposable Medical Supplies	\$0 - \$1,000 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Durable Medical Equipment (DME), Prosthetics, Orthotics <ul style="list-style-type: none"> Rental of durable medical equipment not to exceed purchase price. Prosthetics include artificial limbs or eyes that are initial 	\$0 - \$1,000 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible

Premiera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
Premiera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	No out-of-network benefits are available.
<ul style="list-style-type: none"> replacements of natural body parts. Breast prostheses are replacements of natural body parts lost due to mastectomy. Cochlear implants (device only). Hospital, surgery and therapy services are covered as any other medical condition. Speech aid devices and tracheoesophageal voice devices only after completing a required 3-month rental period. 						
Family Planning <ul style="list-style-type: none"> Vasectomy is covered at 100% in and out of network (deductible applies for HSA plans). Tubal Ligation is covered at 100% in and out of network. Reversals of voluntary sterilization are covered. Norplant and Depo-Provera injections and devices covered under either Medical or Prescription Drug Plan. No copay for injections, if there is no office visit. Oral contraceptives covered through drug plan, not medical plan. Elective abortions covered. Travel & Lodging available; see Travel & Lodging section in SPD for details. 	Vasectomy \$0 copay Tubal Ligation, Norplant, and Depo-Provera \$0 copay Elective abortion: Surgical \$225 copay Non-Surgical \$150 copay	Office Visit PCP: 100% after \$35 copay Specialist: 100% after \$50 copay Inpatient/Outpatient Services 80% after deductible	60% after deductible	80% after deductible	60% after deductible	Office Visit PCP: 100% after \$20 copay Specialist: 100% after \$30 copay Inpatient/Outpatient Services: 80% after deductible
Gender Affirming Care <ul style="list-style-type: none"> Diagnosis and treatment are both covered. Travel & Lodging available; see Travel & Lodging section in SPD for details Out-of-Area HRA coverage 80% after deductible 	\$15 - \$2,750 copay	Office Visit PCP: 100% after \$35 copay Specialist: 100% after \$50 copay Inpatient/Outpatient Services 80% after deductible.	60% after deductible.	80% after deductible.	60% after deductible.	Office Visit PCP: 100% after \$20 copay Specialist: 100% after \$30 copay Inpatient/Outpatient Services 80% after deductible
Hearing Aids <ul style="list-style-type: none"> Limited to one per ear every three calendar years 	\$250 - \$500 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible

Premiera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
Premiera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	<i>No out-of-network benefits are available.</i>	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	<i>No out-of-network benefits are available.</i>
Home Health Care <ul style="list-style-type: none"> Limited to 120 visits each plan year. 1 visit = 4 hours of skilled care services (UHC Only). 	\$70 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Hospice <ul style="list-style-type: none"> Bereavement counseling for family members provided under the EAP plan, not the medical plan. No dollar or day limits. Patient must have life expectancy of 6 months or less. 	Home: \$70 copay Inpatient: \$3,500 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Infertility Benefits <ul style="list-style-type: none"> Fertility treatments are administered through Progyny. Please call (833) 281-0076 to activate benefits Diagnosis and treatment are both covered. 	\$0 - \$2,000 copay	80% after deductible	Not covered out of network	80% after deductible	Not covered out of network	80% after deductible
Inpatient Rehabilitation <ul style="list-style-type: none"> Treatment in a rehabilitation facility. Convalescent—Limited to 120 days each plan year (UHC Plan). Skilled Nursing Facility—Limited to 60 days each plan year. 	Inpatient Rehab: \$3,500 copay Skilled Nursing Facility: \$3,500 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Inpatient Radiologist, Anesthesiologist, Pathologist and Laboratory (RAPs)	\$0 copay	80% after deductible		80% after deductible		80% after deductible (out-of-network providers are covered)
Licensed Naturopath <ul style="list-style-type: none"> No coverage for supplements. Out-of-Area HRA coverage 100% after deductible 	PCP—\$25 - \$130 office visit Specialist—\$25 - \$130 office visit	100% after \$50 copay	100% after \$50 copay	80% after deductible	80% after deductible	100% after \$30 copay
Mammogram <ul style="list-style-type: none"> Due to medical diagnosis. Routine mammograms are covered under Preventive Care. 	\$0 copay	100% no deductible		100% no deductible		100% no deductible
Nutritional Counseling <ul style="list-style-type: none"> Must be provided by dietician or nutritional counselor. Covered for chronic diseases only. Out-of-Area plans' coverage 80% after deductible. Benefits for non-preventive nutritional counseling services for mental health and substance- 	PCP—\$25 - \$130 office visit Specialist—\$25 - \$130 office visit	100% after \$50 copay	60% after deductible	80% after deductible	60% after deductible	100% after \$30 copay

Premera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	No out-of-network benefits are available.
<i>related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.</i>						
Nutritional Supplements / Enteral Feeding <ul style="list-style-type: none"> ■ Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician. ■ Specialized formula defined as nutritional formula for children up to age three that is exempt from nutritional labeling under the FDA and is intended for use solely under medical supervision in the dietary management of a specific disease. 	\$0 - \$1,000 copay	80% after deductible		80% after deductible		80% after deductible
Obesity—Surgical UHC Plan Only: United Resources Network (URN) Bariatric Resources Services Program: <ul style="list-style-type: none"> ■ Benefit provided only for patients 18 and over (additional criteria may apply) ■ National network of facilities with documented quality outcomes for bariatric surgery ■ Travel and lodging benefits available; see Travel & Lodging section in SPD for details ■ Member will be required to complete a pre-surgery psychological evaluation to include a clinical interview and objective diagnostic testing. The use of objective psychological assessment instruments is strongly recommended by the American Society for Bariatric Surgery and required by UHC as part of the assessment. 	\$450 to \$1,950 copay	80% after deductible Please refer to details in Covered Services & Supplies section for coverage requirements	Not covered	80% after deductible Please refer to details in Covered Services & Supplies section for coverage requirements	Not covered	80% after deductible Please refer to details in Covered Services & Supplies section for coverage requirements

Premera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	<i>No out-of-network benefits are available.</i>	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	<i>No out-of-network benefits are available.</i>
Outpatient Hospital Radiation Therapy	Conventional External Beam Radiation Therapy (EBRT): \$70 - \$320 copay Radiation Therapy Simulation and Planning: \$350 - \$1,300 copay Stereotactic Radiation Therapy: \$750 - \$1,450 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Outpatient Lab/X-Ray Services	\$0 copay	80%, no deductible		80% after deductible		80%, no deductible (out-of-network providers are covered)
Outpatient Surgery (at outpatient facility)	\$200 - \$5,000 copay	80% after deductible	60% after deductible. Prior authorization is required for certain outpatient procedures.	80% after deductible	60% after deductible. Prior authorization is required for certain outpatient procedures.	80% after deductible
Outpatient Surgery (at physician's office) <ul style="list-style-type: none"> Out-of-area plans' coverage 80% after deductible. Prior authorization required for certain outpatient procedures. 	\$25 - \$5,000 copay	PCP: 100% after \$35 copay Specialist: 100% after \$50 copay	60% after deductible. Prior authorization is required for certain outpatient procedures.	80% after deductible	60% after deductible. Prior authorization is required for certain outpatient procedures.	PCP: 100% after \$20 copay Specialist: 100% after \$30 copay
Outpatient Therapies <ul style="list-style-type: none"> Physical therapy (75 visits combined with OT). Occupational therapy (75 visits combined with PT). Speech therapy (75 visits/plan year max). Physical, Occupational, and Speech therapy provide a combined maximum of 120 visits per plan year for congenital anomalies, developmental delay, cerebral palsy and hearing impairment. Physical therapy, Occupational therapy, Speech therapy, provides unlimited visits for autism. Provides unlimited visits for behavioral health diagnoses and autism. Out-of-area plans' coverage 80% after deductible. 	Physical Therapy: \$15 - \$90 copay Occupation Therapy: \$15 - \$115 copay Speech Therapy: \$15 - \$115 copay	Office: 100% after \$50 copay	60% after deductible	80% after deductible	60% after deductible	Office: 100% after \$30 copay
Private Duty Nursing	\$70 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible

Premera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721) <i>(Outpatient Only)</i>	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	No out-of-network benefits are available.
Skilled Nursing Facility (Hospital or Free-standing) <ul style="list-style-type: none"> Limited to 60 days each plan year—all plans. Includes lab and therapies. 	\$3,500 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Temporomandibular Joint Disorder (TMJ) <ul style="list-style-type: none"> Dental services are not covered under Medical Plan (see separate benefit under Dental Plan). 	\$700 copay	Office Visit PCP: 100% after \$35 copay Specialist: 100% after \$50 copay Inpatient/Outpatient Services 80% after deductible	60% after deductible	80% after deductible	60% after deductible	Office Visit PCP: 100% after \$20 copay Specialist: 100% after \$30 copay Inpatient/Outpatient Services 80% after deductible
Transplants For both UHC and Premera, travel and lodging available; see Travel and Lodging section of SPD for details. <ul style="list-style-type: none"> Premera Blue Cross Only: An Approved Transplant Center, this is a hospital or other provider that's developed expertise in performing organ transplants and meets other approval standards we use. If none of our centers or the approved transplant centers can provide the type of transplant you need, this benefit will cover a transplant center that meets the written approval standards we follow UHC & Surest Only: National Medical Excellence (NME) Program helps eligible members access covered treatment for solid organ transplants, bone marrow transplants, and certain other rare or complicated conditions at participating facilities experienced in performing these services. If transplant not obtained through transplant network, covered same as any other surgery. 	\$5,000 copay	100%, no deductible or copay if transplant received in transplant network facility. Travel benefits apply. If transplant network facility is not used but hospital is contracted, plan pays 80% after deductible. No travel benefits.	60% after deductible. No travel benefits.	100% after deductible if transplant received in transplant network facility. Travel benefits apply. If transplant network facility is not used but hospital is contracted, plan pays 80% after deductible. No travel benefits.	60% after deductible. No travel benefits.	100%, no deductible or copay if transplant received in transplant network facility. Travel benefits apply. If transplant network facility is not used but hospital is contracted, plan pays 80% after deductible. No travel benefits.

Premera Blue Cross / UHC / Surest	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan¹		High Deductible Plan with Health Savings Account (HSA) Plan¹		Exclusive Provider Organization (EPO) Plan
Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	No out-of-network benefits are available.	IN-NETWORK	OUT-OF-NETWORK¹	IN-NETWORK	OUT-OF-NETWORK¹	No out-of-network benefits are available.
Urgent Care Center <ul style="list-style-type: none"> Out-of-Area plans' coverage 80% after deductible 	\$50 copay	Office Visit 100% after \$50 copay All other covered expenses billed by the urgent care center at 80%, no deductible	60% after deductible	80% after deductible	60% after deductible	Office Visit 100% after \$30 copay Inpatient / Outpatient Services 80% after deductible
Virtual Care Services <ul style="list-style-type: none"> UHC Only: Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting UHC at www.myuhc.com or the telephone number on your ID card. 	\$0 - \$130 copay	100%	Not covered	80% after deductible	Not covered	100%

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** – free, on-demand support for stress, mindfulness and sleep.
- **Calm Health app for employees on a UHC/Surest Medical plan** – 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**—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.

Nurse Line

Premera Blue Cross Members: 24-Hour NurseLine

**Confidential help available:
1-855-429-7236**

The 24-hour NurseLine is available 24 hours a day, 7 days a week, 365 days a year for you and your family. You'll reach a registered nurse who can provide information to assist you with health problems. Getting the best health care begins with asking questions and understanding the answers. The 24-hour NurseLine can help you do that. Whether it's pain, an injury, or a fever that won't go down, advice on what to do is just a phone call away. Your call is answered quickly. The nurse asks you the right questions and helps you decide what to do. The nurse stays on the line as long as it takes to decide what to do and your call is free and confidential.

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

Open Network Dental Plan—Delta Dental of Washington	Maximums and Limits	Delta Dental PPO Provider	Delta Dental Premier Dentist	Non-Participating Dentist
Group #09034	(Plan Year is January 1 through December 31)			
Plan Year Deductible	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
Class I Benefits	Diagnostic and Preventive: Exams, cleanings, fluoride (through age 18), X-rays, and sealants Accidental Injury Treatment	100%	100%	100%
Class II Benefits	Restorative: Fillings, oral surgery, root canals, periodontics	80%	80%	80%
Class III Benefits	Major: Crowns, dentures, bridges, partials, implants, dental night guards (covered at 50% for bruxism every 3 years)	50%	50%	50%
Plan Year Maximum	Per covered individual	\$2,000	\$2,000	\$2,000
Orthodontia Benefits	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
TMJ Benefits	Plan year maximum of \$1,000 per covered individual Lifetime Maximum of \$5,000 per covered individual Confirmation of Treatment and Cost 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
Vision Exam		One exam allowed per plan year.	100% after \$5 copay	Reimbursed up to \$45 after \$5 copay
Lenses	Single Vision	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; Average savings of 30% on other lens enhancements 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
	Lined Bifocal		100% after \$25 copay	Reimbursed up to \$50/pair after \$25 copay
	Lined Trifocal		100% after \$25 copay	Reimbursed up to \$65/pair after \$25 copay
	Elective Contact Lenses		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)
	Medically Necessary Contacts		100% after \$25 copay	Reimbursed up to \$210/pair after \$25 copay
Frames		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 vsp.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

Eligibility for Medical, Dental and Vision

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.

Employee benefits terminate at the end of the month.

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. **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.**

Dependent benefits terminate on the last day of the month that the dependent ceases to be eligible by status or age.

“Dependent” includes the following:

- Legal spouse.
- Same-sex or opposite sex domestic partner including common law spouses.
- You or your spouse's/domestic partner's child up to age 26.
- Unmarried children, age 26 and over, who are fully handicapped prior to the maximum age for eligibility.
- 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.

Qualifying “Change in Status” Events

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:

- Marriage, divorce, legal separation or annulment
- Death of employee's spouse or dependent
- Birth, adoption or placement for adoption, or legal guardianship of a child
- Change in the employee's or employee's spouse employment status impacting eligibility for health coverage.
- Change in worksite or residence
- Adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify under the plan
- Significant change in the employee's spouse's health coverage
- Leave of absence under the Family and Medical Leave Act
- Entitlement to Medicare or Medicaid of the employee, the employee's spouse or dependent
- Spouse becomes, or ceases to be, a tax dependent
- Dependent child turns age 13 and associated dependent care costs are no longer considered eligible expenses under the Dependent Care Flexible Spending Account.
- Change in Dependent Care providers
- Change in cost charged by dependent care provider
- Your hours of service are reduced, to average less than 30 hours of service per week, but you still remain eligible for coverage.
- You would like to cease coverage under T-Mobile's health plan for yourself and any related individuals and purchase coverage through an Exchange.

Flexible Benefit Plans	
Health Care Spending Account	
Contributions	<ul style="list-style-type: none"> ■ Maximum of \$3,300 as pretax contribution per plan year. ■ 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. ■ May not make changes during plan year, EXCEPT for certain qualifying events (see list above). ■ Must re-enroll each plan year.
Reimbursement	<p>Any unreimbursed health care expenses, such as:</p> <ul style="list-style-type: none"> ■ Medical, Dental, and Vision co-pays, co-insurance, and deductibles; ■ Over-the-counter drugs with a prescription or letter of medical necessity; ■ Any other medical, dental, or vision expenses not covered by our plan that would otherwise be considered deductible for tax purposes by the IRS; ■ For an expanded list of eligible expenses, go to www.t-mobilebenefits.com
Limitations	<p>Expenses not eligible for reimbursement include:</p> <ul style="list-style-type: none"> ■ Over-the-counter vitamins or dietary supplements not prescribed by your doctor; ■ Personal care products; ■ Insurance premiums; ■ Cosmetic Surgery.
Dependent Care Spending Account	
Contributions	<ul style="list-style-type: none"> ■ Maximum of \$7,500 as pretax contribution per plan year. ■ May not make changes during plan year, EXCEPT for certain qualifying events (see list above). ■ Must re-enroll each plan year.
Reimbursement	<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"> ■ Dependent child under age 13 for whom you can claim an exemption on your tax return. ■ Dependent or spouse who is physically or mentally incapable of caring for themselves. <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 www.t-mobilebenefits.com</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>
Limitations	<p>Expenses not eligible for reimbursement include:</p> <ul style="list-style-type: none"> ■ Food, clothing or entertainment for a dependent. ■ Expenses for overnight camps, or educational expenses for children in Kindergarten or older (before and after-school care expenses are eligible). ■ Nursing home expenses.
Health Reimbursement Account (HRA)	
Contributions	<ul style="list-style-type: none"> ■ T-Mobile will contribute \$500 for individual coverage or \$1,000 for dependent coverage. ■ Contribution amount is pro-rated based on your month of hire. For example, if you hired in the month of March, T-Mobile would contribute \$417 for individual coverage or \$833 for dependent coverage. ■ Contributions come from T-Mobile. You are not able to make contributions to this account. ■ The full amount of T-Mobile's contribution to your HRA will be available on your first day of coverage.
Reimbursement	<p>Any unreimbursed health care expenses, such as:</p> <ul style="list-style-type: none"> ■ Medical and pharmacy co-pays, co-insurance, and deductibles; ■ Over-the-counter drugs with a prescription or letter of medical necessity; ■ Any other medical expenses not covered by our plan that would otherwise be considered deductible for tax purposes by the IRS; ■ Please contact UHC or Premera for an expanded list of eligible expenses.
Limitations	<ul style="list-style-type: none"> ■ If you enroll in the HRA Plan, you can participate in the Health Care FSA. ■ UHC Only: The HRA will pay first for medical expenses and the Health Care FSA will pay for dental and vision expenses and any remaining medical expenses, once the HRA has been satisfied. This method is referred to as auto rollover. HRA participants have the option to shut off the auto rollover and choose whether to use HRA or Health Care FSA dollars first, by logging onto www.myuhc.com ■ You will forfeit any funds in your HRA if you change/terminate plans.

Flexible Benefit Plans	
Health Savings Account (HSA)	
Contributions	<ul style="list-style-type: none"> ■ T-Mobile will fund \$19.23 per pay period for individual coverage (maximum of \$500/year) or \$38.46 per pay period for dependent coverage (maximum of \$1,000/year). ■ You and T-Mobile are able to contribute to this account. Please refer to the IRS limits below in Limitations.
Reimbursement	<p>Any unreimbursed health care expenses, such as:</p> <ul style="list-style-type: none"> ■ Medical, Dental and Vision co-pays, co-insurance, and deductibles; ■ Over-the-counter drugs with a prescription or letter of medical necessity; ■ Any other medical, dental or vision expenses not covered by our plan that would otherwise be considered deductible for tax purposes by the IRS; ■ Please contact UHC or Premera for an expanded list of eligible expenses.
Limitations	<ul style="list-style-type: none"> ■ If you enroll in the HSA Plan, you or your spouse can't participate in a Health Care Flexible Spending Account (Health Care FSA). ■ IRS limits: \$4,400 for individual coverage and \$8,750 for family coverage. These limits include both employee and employer contributions. ■ Participants age 55 or older can contribute an additional \$1,000. ■ If you turn age 65 and decline Medicare coverage you will be eligible to participate in an HSA plan and receive T-Mobile contributions into an HSA fund.
Childcare Subsidy Program	
	<ul style="list-style-type: none"> ■ Eligible employees can receive up to \$250 per month to help with childcare costs. ■ In order to be eligible, an employee must have a gross annual base pay of \$99,000 or less and be benefits eligible. ■ Enrollment in the subsidy program can only occur at initial eligibility, annual enrollment or due to a qualifying mid-year status change. ■ The childcare subsidy is a per household/family benefit. ■ 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. ■ For more details, visit t-mobilebenefits.com or call the T-Mobile Benefits Center at 1-855-TMO-BENS (855-866-2367).

Carrier/Vendor Information		
Medical Plan UnitedHealthcare Group #222244	Claims address: UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555	United Behavioral Health: (800) 788-5614
	Customer service phone number: (877) 259-1527	Web site info: www.myuhc.com
OptumHealth Bank (for UHC HSA account holders)	Contributions address: OptumHealth Bank P.O. Box 271629 Salt Lake City, UT 84127 1629	OptumHealth Bank: (800) 791-9361
		Web site info: www.optumbank.com , or www.myuhc.com
Medical Plan (including HRA and HSA accounts) Premera Blue Cross	Claims address: Premera Blue Cross PO Box 91059 Seattle, WA 98111-9159	Premera Blue Cross Behavioral Health: (866) 358-2300
	Customer service phone number: (866) 358-2300	Web site info: www.premera.com/T-mobile
Medical Plan Surest	Claims address: Surest P.O. Box 211758 Eagan, MN 55121	
	Customer service phone number: 866-683-6440	Web site info: benefits.surest.com

Carrier/Vendor Information		
CVS Health	<p>Paper claims address: P.O. Box 52136 Phoenix, Arizona 85072-2136</p> <p>Customer care phone number: (844) 757-0417</p> <p>CVS Specialty phone number: (800) 237-2767</p>	<p>CVS Web site info: WWW.Caremark.com</p> <p>CVS Specialty: https://www.cvsspecialty.com/</p>
LiveMagenta (including EAP)	(855) 780-5958	https://livemagenta.com/
<p>Dental Plan Delta Dental of Washington Group #09037 & #09034</p>	<p>Claims address: Delta Dental of Washington P.O. Box 75983 Seattle, WA 98175-0983</p>	<p>Member services phone number: (800) 238-3107</p> <p>Web site info: www.deltadentalwa.com (select "subscribers" area)</p>
<p>Vision Plan Vision Service Plan Group #12122822</p>	<p>Claims address: Vision Service Plan P.O. Box 495933 Cincinnati, OH 45249</p>	<p>Member services phone number: (800) 877-7195</p> <p>Web site info: www.vsp.com</p>
<p>Flexible Spending Account Benefit Plan Your Spending Account</p>	<p>Claims address: Y.S.A. P.O. Box 785040 Orlando, FL 32878-5040</p>	<p>Toll-free Customer Service phone number: (855) TMO-BENS</p> <p>Outside of US: (847) 883-1150</p>
		<p>Toll-free Claims fax number: (888) 211-9900</p> <p>Outside of US: (847) 554-1409</p>
		<p>Web site info: www.t-mobilebenefits.com</p>

Short-Term Disability	Plan Provisions
Broadspire-Plan #022083	
Eligibility	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.
Definition of Earnings	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.
Elimination Period	7 days
Benefit Schedule	85% of your pre-disability earnings for weeks 2 through 26
Minimum/Maximum Weekly Benefit	No Minimum / No Maximum, reduced by deductible income
Definition of Disability	Total Disability or Disabled and Working.
Maximum Period of Benefits	Total of 26 weeks. First week is a waiting period, weeks 2 to 26 are paid.
Integration with Other Income	Direct offset for other sources of income such as state disability benefits, third party payments, retirement benefits, etc.
Exclusions	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.

Long-Term Disability	Plan Provisions
The Hartford—Plan #GLT-402610	
Eligibility	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).
Definition of Earnings	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.
Elimination Period	180 days
Benefit Schedule	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
Minimum/Maximum Monthly Benefit	Minimum: \$100 per month / Maximum: \$20,000 per month
Definition of Disability	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.
Maximum Benefit Duration	Social Security normal retirement age
Integration with Other Income	Direct offset for other income sources such as social security, workers compensation, state disability benefits etc.
Benefits while Working	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.
Rehabilitation Requirements	Mandatory. Employee must participate, unless the disability prevents the employee from participating, or benefits terminate.
Limited Conditions	Some conditions are limited to a 24-month lifetime benefit limit. Please review your plan booklet for details.

Long-Term Disability	Plan Provisions
The Hartford—Plan #GLT-402610	
Pre-Existing Condition Waiting Period	<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>

Basic Life and AD&D	Plan Provisions
The Hartford—Plan #GL-402610 and ADD-S07649	
Eligibility	Day 1 of employment. Full-Time employees (minimum of 30 hours a week). Part-Time employees (minimum of 20 hours a week).
Benefit	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.
Maximum	Maximum of \$1,000,000 of coverage.
Guarantee Issue	An employee is automatically enrolled for Basic Life and AD&D. All coverage is Guarantee Issue.

Voluntary Life	Plan Provisions
The Hartford—Plan #GL-402610	
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	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.
Maximum	Maximum of \$2,000,000 of coverage, combined maximum between Basic and Optional Life of \$3,000,000.
Guarantee Issue	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.

Dependent Life	Plan Provisions
The Hartford—Plan #GL-402610	
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	Spouse/Domestic Partner and children coverage may be purchased separately. <ul style="list-style-type: none"> ▪ Spouse/Domestic Partner: \$10,000, \$25,000, \$50,000, \$75,000, \$100,000, \$150,000, \$200,000 or \$250,000 of coverage ▪ Dependent child(ren): \$10,000 or \$20,000 of coverage per child
Maximums and Limitations	Spousal/Domestic Partner coverage is limited to 100% or less of employee's combined basic and voluntary life coverage amount.
Guarantee Issue	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"> ▪ EE: 100% benefit ▪ Spouse/DP only: 60% benefit ▪ Child(ren) only: 25% benefit ▪ Spouse/DP and Child(ren): 50% Spouse/DP and 25% Child(ren)
Maximums and Limitations	<ul style="list-style-type: none"> ▪ Employee Max: \$2,000,000 ▪ Spouse/DP Max: \$900,000 (sp only) / \$750,000 with Child(ren) ▪ Child(ren) Max: \$100,000
Guarantee Issue	All coverage amounts are guaranteed

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

Business Travel Accident	Plan Provisions
The Hartford—Plan #10-GTA-101903	
Policy Term	1/1/2026-12/31/2026
Eligibility	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.
AD&D Principal Sum	\$500,000 per person per accident.
Coverage Area	Worldwide Travel Business trip coverage 24-hour coverage War risk hazard Covered loss within 365 days of accident
Travel Requirements	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.
Additional Benefits Provided	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.

Business Travel Medical	Plan Provisions
The Hartford—Plan #10-GTA-101903	
Policy Term	1/1/2026-12/31/2026
Eligibility	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
Covered Activities	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
Deductible	\$0
Coinsurance	100%
Calendar Year Maximum	\$250,000
Additional Benefits Provided	Prescription drug, inpatient hospital services, ambulance services, emergency dental, emergency medical evacuation/repatriation of remains

Carrier Information	
The Hartford	<p align="center"> Business Travel Accident 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"> Business Travel Medical 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>