T-Mobile USA, Inc. Employee Benefit Plan

Summary Plan Description for Medical, Dental, Vision, Section 125 Flexible Spending Account, Health Reimbursement Account (HRA) and Health Savings Account (HSA)

Effective January 1, 2027

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Welcome

WHAT'S INSIDE

This Summary Plan Description (SPD) contains important information regarding your benefits under the T-Mobile USA, Inc. Employee Benefit Plan (the "Plan"). This plan provides health and welfare benefits to eligible T-Mobile USA, Inc. Employees. The following benefit summaries are only summaries of these benefits — not complete descriptions in every detail.

This Summary Plan Description, along with the certificates or policies of insurance and the policies and procedures utilized with respect to any adverse benefit determination, shall constitute the ERISA plan document ("Plan Document"). For the sake of convenience, this document will be referred to as the SPD even though it also, together with other documents, serves as the Plan Document.

Every effort has been made to ensure the accuracy of each benefit summary. Should a conflict arise, the legal terms of the appropriate Plan Document, and not the benefit summaries, will control.

INTRODUCTION TO OUR BENEFIT PLANS

The benefits described in this handbook are a valuable part of your total compensation package. They are designed to promote your health and well-being, along with that of your family. They help make necessary health care services more affordable. If you have dependents that need care while you work, there's a benefit plan that can save you money on the cost of that care.

Benefits Offered:

The Plan offers the following benefits, some of which are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"):

- Health and Welfare Program, which includes Medical, Dental, and Vision benefits;
- Health Reimbursement Account (HRA) which is a financial account that allows T-Mobile USA, Inc. to reimburse you for "qualified" health expenses paid by you, under the associated medical plan, to offset health care costs;
- Health Savings Account (HSA) which is a tax advantaged account you can use to pay for qualified health care expenses you or your eligible dependents incur;
- Employee Assistance Program, which provides Elder Care, Child Care, Legal and Financial Counseling referral services, as well as Mental Health and Chemical Dependency assessment and referrals;
- Section 125 Plan which allows you to use before-tax dollars to pay for:
  - Certain health and welfare program benefits
  - Eligible health care expenses — referred to as the Health Care Expense Account
  - Eligible dependent care expenses — referred to as the Dependent Care Expense Account
- Disability Income Plans, which protect a portion of your income if you become too ill or injured to work;
- Life and Accidental Death & Dismemberment (AD&D) Insurance; and
- Business Travel Accident Insurance.

If you live in Hawaii, your medical plans are offered through HMSA. You can choose from a Health Maintenance Organization (HMO) plan that covers only in-network care or a Preferred Provider Organization (PPO) plan that covers both in-network and out-of-network care. Please refer to the separate Summaries of Benefits and Coverage (SBCs) and plan documents for details on your coverage. HMSA can be reached at **1-800-776-4672** (M-F, 8am – 5pm local time) or at www.hmsa.com. T-Mobile's group number with HMSA is 94833.

THE COMPANY'S RIGHTS AND RESPONSIBILITIES

T-Mobile USA, Inc. (sometimes referred to in this SPD as simply the "Company") reserves the right to change, suspend or discontinue the Plan, including any or all of its component programs, in whole or in part, at any time and for any reason. The Company does not promise the continuation of any benefits, nor does it promise any specific level of benefits at, during or after employment. The Plan and its component programs may be changed, suspended or discontinued in whole or in part any time by the Company.

The Plan Administrator has the sole discretionary authority and responsibility to interpret and construe the provisions of the Plan and to determine all factual and legal questions under the Plan, except to the extent that the Plan Administrator has delegated such authority and responsibility to other entities.

Any benefits, rights or obligations of participant and beneficiaries under the Plan following termination of coverage are described in detail in the "Termination" and "Continuation of Health Coverage" sections of this document.

The Summary Plan Description does not create a contract of employment.

HIPAA NOTICE OF PRIVACY PRACTICES (AS OF JANUARY 2026)

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information, including Personal Health Information (PHI), about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Personal Health Information includes

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we disclose
- Get a list of those to whom we've disclosed your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and disclose information to:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and disclose your medical information to:

- Help manage the health care treatment you receive

- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with laws
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and how you can exercise these rights. Our contact information is at the end of this notice.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- Sometimes, we may say "no" to your request. When that is the case, we'll tell you why in writing within 60 days of making that determination.

Request confidential communications

- You may ask us to use a particular method of communication to contact (for example, mobile or office phone or to send mail to a different address).
- We will consider all requests and must say "yes" if your request is reasonable, and you tell us you would be in danger if we do not send confidential communications to the requested address.

Ask us to limit what we use or disclose

- You may ask us not to use or disclose certain health information for treatment, payment, or our operations.
- We are not required to honor to your request, and we may not fulfill certain requests for various reasons, including for example, if doing so would negatively affect your care.

Get a list of those to whom we've disclosed information

- You may ask for a list (accounting) of the times we've disclosed your health information for six years prior to the date you ask, who we disclosed it to, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- If you ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will send you a copy.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your medical information.
- We will make sure that person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you feel we have violated your rights, you may make a complaint using the contact information in the Additional Information section at the end of this notice.
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you may tell us your choices about what we disclose. If you have a clear preference for how we disclose your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Disclose information to your family, close friends, or others involved in payment for your care
- Disclose information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may disclose your information if we believe it is in your best interest. We may also disclose your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never disclose your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or disclose your health information?

We typically use or disclose your health information in the following ways:

- **Help manage the health care treatment you receive**

We may use your health information and disclose it to professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan, so we can arrange additional services.

- **Run our organization**
  - We may use and disclose your information to run our organization and contact you when necessary.
  - We do not use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

- **Pay for your health services**

We may use and disclose your health information as we pay for your health services.

Example: We disclose information about you to your dental plan to coordinate payment for your dental work.

- **Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with an insurer or third-party administrator to provide a health plan, and the insurer or third-party administrator provides your company with certain statistics to explain the premiums charged.

How else may we use or disclose your health information?

We are allowed or may be required to disclose your information for other purposes — usually to contribute to the public good, such as public health and research. We must meet many conditions in the law before we can disclose your medical information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We may disclose health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We may use or disclose your information for health research.

Comply with the law

We will disclose your medical information if state or federal laws require us to do so, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We may disclose your health information with organ procurement organizations.
- We may disclose your health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We may use or disclose health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies (such as medical or nursing boards, or a state health department) for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We may disclose health information about you in response to a court order, administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know if a breach occurs that may have compromised the privacy or security of your information.
- We must provide you with notice of our legal duties and privacy practices as described in this notice and give you a copy of it.
- We will not use or disclose your information other than as described here unless you permit such use and disclosure in writing.

- If you give us permission and change your mind, let us know in writing, and we will update your preferences.

For more information see: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Changes to the Terms of this Notice

We may change the terms of this notice, and the changes will apply to all medical information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Additional Information

Substance Use Disorder (SUD) Records

We generally do not receive or maintain substance use disorder (SUD) treatment records. If we receive them outside the normal course of business, we will protect, and only disclose them, as required or permitted by HIPAA. Some of our health plan business associates may receive SUD treatment records. Those partners will handle SUD records in compliance with HIPAA.

Effective Date of this notice: January 1, 2026.

If a state law relating to the privacy of personal health information provides you with greater privacy protections for, or more rights regarding your medical information than the HIPAA Privacy Rule does, the provisions of that state law will apply.

You may use the following contact information for any questions, complaints, or to exercise your rights described in this notice:

Title:	HIPAA Privacy Officer
Address:	12920 SE 38th Street Bellevue, WA 98006
Telephone Number:	1-866-578-6423
Email:	privacy@t-mobile.com

This notice describes the privacy practices of the group health plan components of the T-Mobile USA, Inc. Employee Benefit Plan (the “Plan”). References to "we" in this notice apply to the health care components of the Plan. The designated health care components of the Plan that are covered by this notice of privacy practices are:

- Medical and prescription benefits, including the HRA
- Dental benefits
- Vision benefits
- Health Care Expense Account benefits
- Employee assistance program benefits

Components of the Plan that are not health care components and therefore not covered by the HIPAA Privacy Rule include, but are not limited to:

- Long-term disability benefits
- Short-term disability benefits
- Accidental death and dismemberment benefits
- Group term life benefits
- Voluntary and dependent term life benefits
- Dependent Care Expense Account benefits

The Plan has appointed a Privacy Officer, who is responsible for making sure the health care components of the Plan treat your information properly. The Privacy Officer may delegate some of their responsibilities to one or more other persons who are identified at the end of this notice. References in this notice to the Privacy Officer also include designees, and communications should be addressed to the appropriate individual(s) identified at the end of this notice.

Title: HIPAA Privacy Officer

Address: 12920 SE 38th Street
Bellevue, WA 98006

Telephone Number: 1-866-578-6423

Email: privacy@t-mobile.com

If you need to contact us for any of the following reasons, use the contact information listed above:

- To request restrictions on use or disclosure of your PHI.
- To request confidential communications of your PHI.
- To access your PHI for inspection and copying.
- To request amendment of your PHI.
- To receive an accounting of disclosures.
- To receive a paper copy of this notice.
- For complaints regarding this notice or our privacy practices.
- For questions about this notice or our privacy practices.

Contact Information For:	
UnitedHealthcare (UHC)	1-877-259-1527
Premera Blue Cross ("Premera")	1-866-358-2300
Surest ("Surest")	1-844 530 0323
CVS Rx (UHC, Surest, and Premera)	1-844-757-0417
Livongo by Teladoc	1-800-835-2362
MyChoice Account FSA Program	1-855-TMO-BENS (1-855-866-2367)
Delta Dental of Washington	1-800-238-3107
Vision Service Plan (VSP)	1-800-877-7195

Common to Medical, Dental, Vision, and Section 125 Flexible Spending Account (FSA) Plans

Special Notice to Employees in Hawaii

Other than your Medical plan, all other benefits in this SPD are as presented. Please refer to your HMSA Plan Summaries or contact HMSA's customer service department at 1-800-776-4672 for additional information on your Medical coverage.

Plan Year

Plan year is a 12-month period from January 1 through December 31.

Eligibility

Eligible Employees

All Regular Full-Time Employees and Regular Part-Time Employees (of T-Mobile, its affiliates or participating related companies) scheduled to work 20 hours or more per week are eligible to participate in the Plan. Employees must work in the United States, be employed by a participating related company in another country or be a T-Mobile Employee on an approved foreign assignment. Refer to your Employee Handbook for Employee status definitions. Notwithstanding the above, an individual who is not treated by T-Mobile as a common law employee of T-Mobile shall be excluded from Plan participation even if a court or administrative agency of competent jurisdiction determines that such individual is a common law employee and not an independent contractor.

Notwithstanding the previous paragraph, former employees of Sprint Corporation and its affiliates who are entitled to receive benefits continuation under the Sprint Separation Plan dated November 2, 2015 (the "Separation Plan") are Eligible Employees under this Plan for purposes of those benefits eligible for continuation as described in the Separation Plan for the duration of the Separation Pay Period as defined in the Separation Plan. At the end of the Separation Pay Period, any Eligible Employee described in the preceding sentence shall cease to be an Eligible Employee under this Plan.

Eligible Dependents

Dependents are:

- A legal **Spouse** (wife or husband), including a Common Law Spouse of an Eligible Employee as recognized by federal law.
- A Same-sex or Opposite Sex **Domestic Partner** (referred to as "Domestic Partner" throughout this Summary Plan Description).
  - A **Domestic Partner** is a person who has a single, dedicated relationship with the Eligible Employee in which both the Eligible Employee and Domestic Partner:
    - Are at least eighteen (18) years of age and mentally competent to consent to contract.
    - Are in a relationship that is intended to last indefinitely.
    - Share the same permanent residence.
    - Are not related by blood to a degree of closeness that would prohibit marriage under the laws of the state in which they reside.

- Are not married to, or a Domestic Partner of, another person under the statutory or common law.
- Are financially interdependent and have provided the Employer with either a notarized Affidavit of Domestic Partnership or a domestic partner registry certificate.
- Are mentally competent and legally qualified in their state of residence to contract.

- Employees are advised to consult an attorney regarding the possibility that the filing of a notarized Affidavit of Domestic Partnership may have other legal and/or financial consequences, including the fact that it may, in the event of termination of the domestic partnership, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for purposes of establishing and dividing community property, assigning community debt, and for the payment of support.

- A dependent **Child** of an Eligible Employee who is under age 26.
  - **Child** includes the following:
    - A biological child.
    - A stepchild*.
    - A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)
    - A child of a Domestic Partner.
    - Any other child for whom the Eligible Employee is the court-appointed legal guardian.
  - Certain **Children** age 26 and over will be included as Dependents regardless of age. The Child must meet all the following conditions:
    - The Child is mentally or physically incapacitated prior to the maximum age for eligibility.
    - The Child is not capable of self-support.

The Company will require documentation to verify Dependent eligibility prior to the start of coverage.

Dependents must reside or maintain a permanent address in the United States or be accompanying a T-Mobile Employee on an approved foreign assignment or an employee working for a participating related company in another country.

* *Coverage for a stepchild will continue in the event the birth parent (the legal Spouse of the Eligible Employee) passes away, as long as the stepchild continues to meet the other eligibility requirements of this section and the Eligible Employee has not terminated employment with T-Mobile (subject to the rules for continuing coverage under COBRA). In the case of divorce, the stepchild does not retain eligibility if they do not meet other eligibility requirements.*

NOTE: *Premiums for coverage of Eligible Employees' Domestic Partners or Children of Domestic Partners shall be on an after-tax basis. Health care expenses for these individuals are not eligible under Flexible Spending Accounts.*

COST OF COVERAGE

Our health plan coverages are self-insured. This means that all benefits under our health plans are paid from the general assets of T-Mobile USA, Inc. Required Employee contributions are used to partially reimburse T-Mobile USA, Inc. for benefits under the health plans. Employee required contributions may increase from time to time at the company's sole discretion.

If an Employee enrolls a Spouse or Domestic Partner on a T-Mobile health plan, and the Spouse/Domestic Partner has access to coverage through their employer-sponsored medical plan but does not enroll, a monthly surcharge will apply.

Premiums for coverage of Employees' Domestic Partners or Children of Domestic Partners shall be on an after-tax basis. Health care expenses for these Dependents are not eligible under Flexible Spending Accounts or Health Savings Account.

Employees on leave of absence will continue to pay for medical, dental, and vision coverage. Any missed deductions will be accrued in arrears and taken once pay is available.

ENROLLMENT REQUIREMENTS

Employee Coverage

- An Employee enrolls for Employee coverage by completing online enrollment via the T-Mobile Benefits website at http://www.t-mobilebenefits.com, or by calling the T-Mobile Benefits Center at **1-855-TMO-BENS** (**1-855-866-2367**).
- An Employee may enroll during the Initial Eligibility Period, Open Enrollment Period, or a Special Enrollment Period.

Dependent Coverage

- An Employee must enroll for coverage in order to enroll their Dependents. If a husband and wife or two partners are both Eligible Employees, their Dependents may only be enrolled for coverage under one or the other Employee, but not both.
- An Employee may not be enrolled as both an Employee and a Dependent under the Plan.
- Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.
- Subsequent Dependents are any family members who become Eligible Dependents after the date the Employee first becomes eligible under the Plan. Subsequent Dependents may be added during a Special Enrollment Period as a result of a qualifying family status change event or during an Annual Enrollment Period.
- A Dependent's enrollment may occur during the Initial Eligibility Period, Annual Enrollment Period, or a Special Enrollment Period.
- Dependent coverage is subject to Dependent Verification prior to the effective date of coverage. Failure to complete Dependent Verification will result in removal of enrollment elections.

Mental Health and Wellbeing Program — LiveMagenta (Lyra Health, Grokker and MySecureAdvantage)

- Enrollment Requirements do not apply to the LiveMagenta Mental Health and Wellbeing Program.
- EAP coverage is automatic and begins on your first day of employment as an Eligible Employee.
- You do not have to enroll in the health benefits plan to access Lyra's counseling, coaching, digital self-care, or wellbeing resources.
    - However, certain Lyra services, such as medication management or continued therapy beyond the 10 sessions per issue per year, are available only to employees and dependents enrolled in a T-Mobile medical plan. These services are covered under your medical plan's outpatient mental health benefit and are subject to its deductible and cost-sharing provisions.

ENROLLMENT PERIODS

The Initial Eligibility Period is the period beginning the day an Employee is first eligible for benefits (most often the Employee's date of hire) through the last day of the month prior to the Employee's Eligibility Date (benefits effective date).

For example, if an Employee's date of hire is June 3, the Employee's Eligibility Date (effective date) for benefits is August 1. Therefore, the Employee's Initial Enrollment Period is June 3 to July 31.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Open Enrollment Period, or the occurrence of a qualifying family status change event to enroll for coverage.

The Employer designates the Open Enrollment Period prior to the start of each Plan Year. During this period, all Eligible Employees and Dependents can enroll for coverage.

When a Special Enrollment applies for an Employee, the Employee may enroll in the Plan without waiting for the next Open Enrollment Period to occur. If an Employee's Spouse or Child has a Special Enrollment right, the Employee may enroll their

Spouse or Dependent and may change their own coverage from one plan choice to another, just as is permitted during the Open Enrollment Period.

Special Enrollment Period for Loss of Other Coverage

A Special Enrollment Period is available for Employees and their Dependents who lose coverage under another health plan if the following conditions are met:

- The Employee or Dependent is eligible for coverage under the Plan but not enrolled.
- Enrollment in the Plan was previously offered to the Employee.
- The Employee declined coverage under the Plan because, at the time, the Employee and/or Dependent was covered by another group health plan or had other health insurance coverage.
- The Employee declared that the reason for the declination was the other coverage.
- The current Employee or Dependent may request Special Enrollment within 31 days of loss of other health coverage under the following circumstances:
  - If the other group coverage is COBRA, Special Enrollment can only be requested after exhausting COBRA coverage.
  - If the other group coverage is not COBRA, Special Enrollment can only be requested after losing eligibility for the other coverage due to a COBRA qualifying event. COBRA continuation does not have to be elected in order to preserve the right to a Special Enrollment.
  - If the other group coverage is not COBRA, Special Enrollment can be requested upon cessation of employer contributions for the other coverage.
  - If the other individual or group coverage does not provide benefits to individuals who move outside their service area and (in the case of group coverage) no other benefit packages are available, Special Enrollment can be requested upon moving outside the service area.
  - If the other plan no longer offers benefits to the class of similarly situated individuals, Special Enrollment can be requested upon such plan change.
- A Special Enrollment is not available if a loss of coverage is due to failure to pay premiums on a timely basis or termination of coverage for cause.
- The effective date of coverage under the Plan will be the date of the event.

Special Enrollment Period for Subsequent Dependents

The Dependent Special Enrollment Period for the T-Mobile medical, dental and vision plans is the 31-day period that begins with the date the person becomes a Dependent. Refer to Section “Effective Date of Dependent Coverage” for definitions of effective dates for Subsequent Dependents.

Except — For Newborn, Newly Adopted Children and Children acquired through legal guardianship or Domestic Partnership, the Dependent Special Enrollment Period is the 60-day period that begins with:

- The date of birth.
- The date of adoption or placement for adoption.
- The date you are appointed legal guardian of the Child.
- The date of Domestic Partnership.

The above exception does not apply to the HMSA medical plan for Hawaii Employees. The Special Enrollment Period for all family status changes is 31-days under the HMSA medical plan for our Hawaii Employees.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered.

NOTE: *Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.*

Special Enrollment for Loss of State Children's Health Insurance Program (CHIP) or Medicaid

A Special Enrollment Period is available for current Employees and their Dependents who are otherwise eligible for coverage under the Plan, if one of the following events occurs:

- The Employee's or Dependent's state CHIP or Medicaid coverage is terminated due to a loss of eligibility.
- The Employee or Dependent becomes eligible for state CHIP or Medicaid premium assistance.

The current Employee or Dependent may request the special enrollment within 60 days from the date other coverage is lost or within 60 days from the date that premium assistance eligibility is determined.

The effective date of coverage under the Plan will be the date of the event.

Rescission of Coverage

T-Mobile USA, Inc. reserves the right to terminate the health care coverage of you and/or your Dependent prospectively without notice for cause (as determined by T-Mobile USA, Inc.), or if you and/or your Dependent are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your Dependent commits fraud or intentional misrepresentation in an application for health coverage under the Plan, in connection with a benefit claim or appeal, or in response to any request for information by T-Mobile USA, Inc. or its delegates, T-Mobile USA, Inc. may terminate your coverage retroactively upon 30 days' notice.

EFFECTIVE DATE OF EMPLOYEE COVERAGE

Employee coverage is effective on the first day of the month following 30 days of continuous employment as long as the Employee enrolls prior to the first day of becoming eligible. Employee contributions begin the first of the month that you become eligible.

Example: Your first day of employment is June 3. Your effective date for coverage is August 1, as long as you enroll by July 31. In this example, you will be responsible for contributions as of August 1.

- **Except** — EAP coverage is automatic and begins on your first day of employment as an Eligible Employee. Employee contributions are not required for EAP coverage.
- **Except** — Basic Life and Basic AD&D insurance coverage are automatic and begin on your first day of employment as an Eligible Employee. Employee contributions are not required for Basic Life and Basic AD&D insurance coverage.

T-Mobile may from time to time choose to apply service earned at an acquired company or Deutsche Telekom towards the eligibility waiting period.

EFFECTIVE DATE OF DEPENDENT COVERAGE

Coverage for initial enrollment of a Spouse, Domestic Partner, or eligible Dependent Child is effective on the **Employee's coverage effective date** as long as the Dependents are enrolled within the Employee's initial eligibility period and dependent verification has been satisfactorily completed.

Coverage for a Subsequent Dependent is effective as follows:

- For a Spouse or Domestic Partner, the date of the marriage or the date of partnership, as indicated on the notarized Domestic Partner Affidavit.
- For a newborn, the date of birth.
- For an adopted Child, the date of adoption or placement for adoption.

- For a Child acquired through legal guardianship, the date of guardianship.
- For a Child who is required to be enrolled by a court order (as determined by the Plan Administrator to be a Qualified Medical Child Support Order), the date of the order.
- For any other Child, the date the Child becomes a Dependent.

The Employee must enroll Subsequent Dependents in coverage within 31 days of the Dependent becoming eligible and complete dependent verification. **This requirement applies even if you already have family coverage.**

- **Except** — EAP coverage is automatic and begins on the date the Spouse, Domestic Partner or Child becomes your Eligible Dependent.

SPECIAL PROVISION FOR NEWBORN AND NEWLY ADOPTED CHILDREN AND CHILDREN NEWLY ACQUIRED THROUGH GUARDIANSHIP OR DOMESTIC PARTNERSHIP

Employees have up to 60 days (31 days for Hawaii Employees*) to enroll a newborn, newly adopted Child or Child newly acquired through guardianship or domestic partnership. This Special Enrollment Period begins on the day of birth, the day of adoption or placement for adoption or the day you are appointed legal guardian of the Child.

Medical Plan Convention Regarding Newborns

If the mother is a covered member under the Plan, Plan Benefits are payable for a newborn Child for the first 31 days of life, even if the Employee has not enrolled the Child. During this 31-day period, the Child will be enrolled under its own claim file and will be subject to its own deductible, coinsurance maximum and other provisions of the Plan. However, the Employee must enroll the Child within 60 days of birth for their coverage to continue. Enrollment is NOT automatic. Please note that initial hospital newborn expenses are not subject to their own deductible on EPO and HRA plans if a newborn is released with the mother (otherwise a separate deductible applies).

NOTE: *This convention does not apply to Hawaii Employees. Hawaii Employees must enroll all Subsequent Dependents, including newborns, within 31 days for coverage. Refer to your HMSA documentation for more information.*

REINSTATEMENT OF FORMER PARTICIPANT

Subject to the Special Rules noted above, if you terminate employment or cease to be an Eligible Employee and are rehired or return to status as an Eligible Employee during the same Plan Year in which you terminated or ceased to be eligible, and the rehire or return to status occurs within 30 days of the termination or cessation, you are required to participate for the remainder of the Plan Year by continuing your original election for that Plan Year on a pro rata basis. If you are rehired within 30 days in a different Plan Year, a new enrollment opportunity is provided. The effective date of coverage is the first of the month following date of rehire.

If more than 30 days pass (but less than 13 weeks pass) and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following date of rehire.

If 13 weeks or more pass, and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following 30 days of continuous employment after date of rehire.

SECTION 125 FSA ENROLLMENT AND PARTICIPATION

You are eligible to participate in our Section 125 Flexible Spending Account Plans ("FSA Plans") beginning the first of the month following 30 days of continuous employment. You must enroll by the last day of the month prior to becoming eligible to participate. If you enroll prior to becoming eligible to participate, your coverage effective date under the FSA Plans will be the first of the month following your election.

If you do not join an FSA Plan when you are initially eligible, you will have to wait until the next Open Enrollment Period to join, unless you experience a mid-year qualifying event. For all subsequent plan years, you will have an opportunity to enroll during the Open Enrollment Period. You must enroll by the last day of the Open Enrollment Period. If you satisfy this requirement, then you will become a participant in the FSA Plan(s) you elect on the first day of the upcoming plan year. If you fail to enroll by the last day of the Open Enrollment Period, you may not enroll in an FSA Plan until the next Open Enrollment Period, unless you experience a mid-year qualifying event.

Special Provision for Newborn and Newly Adopted Children and Children Newly Acquired by Guardianship: You have up to 60 days to enroll newborn and newly adopted Children and Children newly acquired by guardianship. (Hawaii exception: The Special Enrollment Period for all family status changes is 31 days for Hawaii Employees.) Your Section 125 FSA Plan contributions will be retroactive to the first pay period of the month following the date of birth, the date of adoption or placement for adoption. FSA Plan contributions for children newly acquired by guardians shall be made on a post-tax basis for the retroactive coverage period and on a pre-tax basis beginning with the first pay period following receipt of your enrollment.

You must re-enroll in the FSA Plans each Open Enrollment Period. If you fail to do so, you will be deemed to have elected not to participate in any FSA Plan.

QUALIFYING FAMILY STATUS CHANGE EVENTS

Your coverage remains in effect for an entire plan year (January 1 to December 31). IRS regulations require elections made under Section 125 Plans (pre-tax basis) to continue for the entire plan year. This means that you may not drop, terminate, discontinue, or change your coverage for the entire term of the plan year unless you meet the criteria of qualifying family status change event.

You may change your coverage mid-year only if you have a qualifying change in family status. Qualifying family status changes include:

- Marriage
- Divorce, legal separation, or annulment
- Beginning/ending domestic partnership relationship
- Birth, adoption or placement for adoption, or legal guardianship of a Child
- Death of your Spouse/Domestic Partner or eligible dependent Child
- Leave of absence under the Family and Medical Leave Act
- Entitlement to, or lost coverage under, Medicare or Medicaid of the Employee, the Employee's Spouse/Domestic Partner or Dependent
- Change in eligibility status for a Child
- Change in you or your Spouse/Domestic Partner's employment status impacting eligibility for health coverage (such as losing a job or becoming employed, or taking an unpaid leave of absence)
- "Significant change" in your Spouse/Domestic Partner's health coverage (not applicable to changes in FSA elections). "Significant change" is determined by the Plan Administrator in accordance with relevant guidance
- 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
- Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility
- You or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP

- Your hours of service are reduced, to average less than 30 hours of service per week, and you still remain eligible for coverage, but you would like to cease coverage under T-Mobile's health plan for yourself and any related individuals and purchase coverage through an Exchange

Any requested enrollment change must be consistent with the qualifying change in family status. Refer to the chart below. In addition, T-Mobile reserves the right to request documentation from you for proof of the family status change, and to verify eligibility of newly enrolled dependents.

If you wish to change coverage due to a qualifying family status change, you have 31 days beginning with the date of the event to complete a new benefit enrollment online at http://www.t-mobilebenefits.com or by calling the T-Mobile Benefits Center at **1-855-TMO-BENS** (**1-855-866-2367**). Enrollment after the 31-day window will be denied. If denied, you must wait until the next Open Enrollment Period to make your status change. For the bullets related to CHIP noted above, you have 60 days beginning with the date of the event to notify the Plan Administrator if you wish to make a coverage change.

Special Provision for Newborn, Newly Adopted Children and Children Acquired Through Legal Guardianship or Domestic Partnership: You have up to 60 days to enroll newborn, newly adopted Children and Children acquired through legal guardianship or domestic partnership. (Hawaii exception: The Special Enrollment Period for all family status changes is 31-days for Hawaii Employees.) Premiums for children newly acquired by guardians or domestic partners shall be made on a post-tax basis for the retroactive coverage period and on a pre-tax basis beginning with the first pay period following receipt of your online enrollment transaction (but only if they are your tax dependents). If the mother is a covered member under the Plan, Plan Benefits are payable for a newborn Child for the first 31 days of life, even if the Employee has not enrolled the Child.

It is also your responsibility to access the benefits website at http://www.t-mobilebenefits.com or call the T-Mobile Benefits Center at **1-855-TMO-BENS** (**1-855-866-2367**) to remove your dependent from coverage within 31 days of the date a dependent is no longer eligible. If you do not give timely notice:

- You will be responsible for reimbursing the Plan for any claims paid for ineligible dependents.
- You may change your election with respect to contributions for the rest of the plan year. However, you will not receive a refund for any months during which the dependent was not eligible, but no change was made, due to your failure to notify T-Mobile that the qualifying change in family status occurred.

If you wish to make a change to your elections, it is your responsibility to access the benefits website at http://www.t-mobilebenefits.com or call the T-Mobile Benefits Center at **1-855-TMO-BENS** (**1-855-866-2367**) within 31 days of your qualifying event.

QUALIFYING EVENT TABLE

Qualifying Event	Impact on Eligibility for Health & Welfare Plans	Impact on Health Care Spending Account	Impact on Dependent Care Spending Account / Childcare Subsidy
If you gain a dependent Child: ■ Birth of Child ■ Adoption or Placement for adoption ■ Legal Guardianship	You may enroll yourself; or you and your Spouse or Domestic Partner; or you, your Spouse or Domestic Partner and newborn or newly adopted Child[1]	Enroll in plan, or change contribution	Enroll in plan, or change contribution

[1] *Other previously eligible but not enrolled dependent Children may not be enrolled mid-year under these Qualifying Events—you may add these Dependents during the Open Enrollment Period.*

Qualifying Event	Impact on Eligibility for Health & Welfare Plans	Impact on Health Care Spending Account	Impact on Dependent Care Spending Account / Childcare Subsidy
If you get married	You may enroll yourself; or you and your Spouse; or you, your Spouse and newly dependent Children[1]	Enroll in plan, or change contribution	Enroll in plan, or change contribution
If you obtain a Domestic Partner	You may add Dependent	No change	No change
If you get divorced, or an annulment, or legally separated from your Spouse	You must delete Dependent, and you may add coverage for self and/or Dependents if previously covered under Spouse's plan and not this plan[2]	Enroll in plan, or change contribution	Enroll in plan, or change contribution
If you separate from a Domestic Partner	You must delete Dependent, and you may add coverage for self and/or Dependents if previously covered under Domestic Partner's plan and not this plan[2]	No change	No change
If a Spouse dies	You must delete Spouse and you may add coverage for self and/or Dependents if previously covered under your Spouse's plan and not this plan2	Enroll in plan, or change contribution3	Enroll in plan, or change contribution
If a Dependent dies	You must delete Dependent	Decrease or cease contribution3	Decrease or cease contribution
If there is a significant change to your employed Spouse's health plan	You may add or delete Dependent2	No change	No change
If there is a significant change in the cost of your, or your employed Spouse's, health coverage premiums	You may add or delete Dependent2	No change	No change

[2] *It is the Employee's responsibility to notify the Plan Administrator of any Dependents no longer eligible—this includes, but is not limited to, Dependents lost due to divorce, death, or a dependent Child over limiting age. Paid premiums will not be retroactively reimbursed if Employee fails to make timely notification of status change.*

[3] *The total of the new election amount plus payroll deductions as of the effective date of the new election cannot be less than the total reimbursements as of the effective date of the new election.*

Qualifying Event	Impact on Eligibility for Health & Welfare Plans	Impact on Health Care Spending Account	Impact on Dependent Care Spending Account / Childcare Subsidy
If your, or your Spouse's employment status changes impacting eligibility for health coverage[4]			
▪ Start new job	▪ You may enroll in plan or drop coverage[5] ▪ You may add or delete Dependent[4]	Enroll in plan or change contribution	Enroll in plan or change contribution
▪ Stopped working		Enroll in plan or change contribution	Decrease or cease contribution
▪ Changed from part-time to full-time		Enroll in plan or change contribution	Enroll in plan or change contribution
▪ Changed from full-time to part-time		Enroll in plan or change contribution	Decrease or cease contribution
▪ Became eligible under Spouse's employer-sponsored plan		Decrease or cease contribution	Decrease or cease contribution
▪ Lost eligibility under Spouse's employer-sponsored plan		Enroll in plan or increase contribution	Enroll in plan or increase contribution
If you are making election changes during your Spouse's health plan's open enrollment period	▪ You may enroll in plan or drop coverage[5] ▪ You may add or delete Dependent[5]	No change	No change
If you are going on unpaid leave under the Family Medical Leave Act of 1993[6]	You may drop coverage while on leave	Cease contributions or continue on an after-tax basis	Cease contributions or continue on an after-tax basis
If you are returning from unpaid leave under the Family Medical Leave Act of 1993[6]	You may reinstate coverage upon return from leave	You may resume coverage at prior level or pro-rate for missed contributions	You may reinstate election

[4] *Status change is changing part-time to full-time, full-time to part-time, gain or termination of employment. For information on part-time and full-time classifications, please refer to the Employee Handbook or contact Human Resources.*

[5] *It is the Employee's responsibility to notify the Plan Administrator of any Dependents no longer eligible—this includes, but is not limited to, Dependents lost due to divorce, death, or a dependent Child over limiting age. Paid premiums will not be retroactively reimbursed if Employee fails to make timely notification of status change.*

[6] *Even if you do not elect continuation coverage during FMLA, you will not experience a waiting period upon your return to work. Contact your T-Mobile Benefits Center.*

You will continue to pay premium deductions while on leave. Any missed deductions will be accrued in arrears and deducted once pay is available.

Qualifying Event	Impact on Eligibility for Health & Welfare Plans	Impact on Health Care Spending Account	Impact on Dependent Care Spending Account / Childcare Subsidy
If you are entitled to special enrollment rights under HIPAA	▪ You may enroll in plan ▪ You may add or delete Dependent ▪ You and Dependents may change plans	No change	No change
If you change residence or workplace location[7]	▪ Applies to change of residence or workplace by Employee[7] ▪ You and Dependents may change to Out-of-Area plan	No change	No change
If an otherwise eligible Child reaches the plan's limiting age	You must delete Child[8]	Decrease or cease contribution[9]	No change
If you are required to provide health coverage for dependent Child (Qualified Medical Child Support Order)	You may add Dependent	Enroll in plan or increase contribution	No change
If you are no longer required to provide health coverage for dependent Child (Qualified Medical Child Support Order is revoked)	You may delete Dependent[8]	Decrease or cease contribution	No change
If you or your Spouse or dependent Child becomes eligible for Medicaid or Medicare	You may delete Dependent	Decrease or cease contribution	No change
You, your Spouse, or dependent Child loses coverage under Medicare or Medicaid	▪ You may enroll in plan ▪ You may add Dependent	Enroll in plan or increase contribution	No change

[7] *A move that causes significant changes to network access. "Significant change" is defined at the Plan Administrator's sole discretion.*

[8] *It is the Employee's responsibility to notify the Plan Administrator of any Dependents no longer eligible—this includes, but is not limited to, Dependents lost due to divorce, death, or a Child attaining the limiting age. Paid premiums will not be retroactively reimbursed if Employee fails to make timely notification of status change.*

[9] *The total of the new election plus payroll deductions as of the effective date of the new election cannot be less than the total reimbursements as of the effective date of the new election.*

Qualifying Event	Impact on Eligibility for Health & Welfare Plans	Impact on Health Care Spending Account	Impact on Dependent Care Spending Account / Childcare Subsidy
Midyear election change to move to Marketplace Coverage by a dependent of a participant who is eligible for a Marketplace SEP or during Marketplace open enrollment	You may delete dependent	No change	No change
Dependent Child turns age 13 and associated dependent care expenses are no longer eligible	No change	No change	Decrease or cease contribution
Changed dependent care providers	No change	No change	Enroll or change contribution
Change in cost charged by dependent care provider	No change	No change	Increase or decrease contribution
Significant coverage or provider access curtailment	You may change to the Out-of-Area plan	No change	No change

Documentation Required for Qualifying Events:

Type of Change	Effective Date of Change	Documentation Required	Dependent Verification
Marriage	Date of marriage	Marriage Certificate (license is not acceptable)	You will be subject to dependent verification; therefore, additional documentation will be requested at that time
Divorce / Legal Separation / Annulment	Date of divorce	Divorce Decree or Notice of Legal Separation / Annulment	Not Applicable
Birth / Adoption (60 days are allowed)	Date of birth / placement	Birth Certificate / Adoption Decree — do not need SSN	You will be subject to dependent verification; therefore, additional documentation will be requested at that time
Child gained due to Legal Guardianship or Domestic Partnership (60 days are allowed)	Date of legal guardianship or domestic partnership	Court order granting custody	You will be subject to dependent verification; therefore, additional documentation will be requested at that time
Child Loss of Eligibility — Age 26	1st of the month following 26th birthday	No documentation required	Not applicable
Death	Date of death	Death Certificate	Not applicable
Employee gaining other coverage and wanting to cancel	Date new coverage is gained	Proof of gain of coverage, including names of covered members and coverage effective date	Not applicable
Loss of Other Coverage	Date other coverage is lost	Proof of loss of coverage, including names of covered members and coverage end-date	You will be subject to dependent verification; therefore, additional documentation will be requested at that time
New Domestic Partnership [10]	Date of partnership	Verification of shared residence, such as a copy of the lease, and documentation of financial interdependence, such as joint bank account or bill	You will be subject to dependent verification; therefore, additional documentation will be requested at that time

[10] *Refer to Domestic Partner Affidavit for specific requirements.*

ALL CHANGES ARE EFFECTIVE THE DATE OF THE QUALIFYING STATUS CHANGE, INCLUDING FOR BIRTH, ADOPTION, PLACEMENT FOR ADOPTION OR CHILDREN ACQUIRED THROUGH LEGAL GUARDIANSHIP. (FSA ELECTIONS ARE EFFECTIVE THE FIRST OF THE MONTH FOLLOWING TIMELY ELECTION, INCLUDING ELECTION CHANGES DUE TO A QUALIFYING FAMILY STATUS CHANGE. THIS INCLUDES FSA ELECTION CHANGES DUE TO BIRTH, ADOPTION, PLACEMENT FOR ADOPTION OR CHILDREN ACQUIRED THROUGH LEGAL GUARDIANSHIP.)

TERMINATION OF COVERAGE

Employee and Dependent Coverage in Health Plans and Participation in Section 125 Plan

Employee and Dependent coverage/participation ends on the day the Plan is terminated or the following (if earlier):

Health Plans

- The last day of the month in which you stop being an Eligible Employee/Dependent; or (if later) the last day of the month in which you are paid for working as an Eligible Employee.
- The last day of a period for which contributions for the cost of coverage have been made if the contributions for the next period are not made when due.
- See also "Disability" and "Leave of Absence" below.

Section 125 Plan

- The day you terminate employment.
- The day you cease to be an Eligible Employee.
- See "COBRA Section 125 Plan Participation" for exception regarding Health Care and Dependent Care Spending Accounts.

Disability

The Employer has the right to continue a person's employment and coverage under this Plan during a period in which the person is away from work due to disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Coverage ends on the date the Employer notifies the Claims Administrators that the person's employment has ended, and coverage is to be ended, or the date pursuant to Employer policies regarding the length of the disability continuation period.

Leave of Absence

The Employer has the right to continue the person's employment and coverage under this Plan during a period in which the person is away from work due to an approved leave of absence.

Coverage ends on the date the Employer notifies the Claims Administrators that the person's employment has stopped, and coverage is to be ended, or the date pursuant to Employer policies regarding the length of the continuation period.

Continuation of Health Coverage During Military Leave

Employees going into or returning from military service may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). These rights apply only to Eligible Employees and Eligible Dependents who were covered by the Plan immediately before the Employee's leave for military service began.

The maximum USERRA coverage period is 24 months. However, the USERRA extension will terminate earlier if the military leave ends and the Employee fails to return to employment.

A person who elects to continue coverage may be required to pay up to 102% of the full contribution. However, a person on active duty for less than 31 days will be charged the same amount as an active Employee.

This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Contact the T-Mobile Benefits Center or refer to your Employee Handbook to find out details about how this continuation applies to you.

Continuation of Health Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 workweeks of unpaid, job-protected leave during the Employer's leave year to FMLA-eligible employees for certain family and medical reasons, or up to a total of 26 workweeks of unpaid, job-protected leave during a single 12-month period for military caregiver leave. Employees may continue their benefits under the group health component programs of the Plan during FMLA leave on the same terms as if the Employee had continued to work during the FMLA leave. Employees who choose to do so are required to continue to make Employee contributions during the period of FMLA leave in order to maintain coverage during FMLA leave. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Contact the T-Mobile Benefits Center or refer to your Employee Handbook to find out details about how this continuation applies to you.

Continuation of Section 125 Plan During Family and Medical Leave (FMLA)

If you are on a continuous leave of absence under the Family and Medical Leave Act (FMLA) during which accrued PTO and/or Legacy Sick Leave are not being used, your employer may allow you to discontinue your election. Please see your Employer regarding their policy in this matter and refer to the Employee Handbook for information regarding accrual and use of PTO and Legacy Sick Leave.

Should your Employer allow you to discontinue coverage during these circumstances, you will not be eligible to incur or be reimbursed for any expenses during the period of non-coverage. Your Employer may require you to re-enroll in the Plan upon your return from continuous FMLA leave if your Employer also requires Employees who return from continuous non-FMLA leave to re-enroll in the Plan. If your Employer requires re-enrollment in the Health Care Spending Account, you must be allowed to choose one of the following two payment options:

Proration: *You may elect to reinstate a level of coverage that is reduced by the amount of contributions missed during the continuous FMLA leave based on the original plan year contribution election amount; or*

Continuance of Annual Election: *You may elect to continue the level of coverage that was in effect when the leave commenced, so long as your new monthly contribution is adjusted to include any contribution amounts missed during the continuous FMLA leave. Claims for expenses incurred during your leave period (i.e., period of time which coverage was discontinued) will not be covered.*

Should you not return to employment at the conclusion of the FMLA leave, your Employer may be entitled to recover any contributions that your Employer has paid on your behalf while you were on unpaid FMLA leave.

Should your Employer allow you to choose between the options of discontinuation or continuation of your Plan during continuous FMLA leave, you may elect to continue coverage, by making the applicable contributions in the following modes as permitted under the rules established by the Plan Administrator and in compliance with FMLA regulations:

- Pre-payment made prior to the commencement of the FMLA period on a pre-tax or after-tax basis; or,
- "Pay-as-you-go" basis during the term of the leave on an after-tax basis or pre-tax basis to the extent that the contributions are made from taxable compensation.
- Catch-up salary reduction (or after-tax payment) upon return from the leave.

Should you select the "pay-as-you-go" option and you fail to make the required contributions, your Employer may terminate coverage under the Plan.

If PTO and/or Legacy Sick Leave are used during continuous FMLA leave, your Employer may, at its discretion, require that you continue to participate in the Plan, as long as your Employer requires continuation of coverage during an Employee's continuous non-FMLA leave during which PTO and/or Legacy Sick Leave are used. Please see your Employer regarding their policy in this matter.

While on FMLA leave, you have the same rights regarding open enrollment and status change election modifications as those Employees participating in the Plan who are not on FMLA leave.

Pursuant to IRS regulations, the Plan will reimburse eligible claims under the Health Care Spending Account up to the full amount of the elected coverage so long as your coverage under the Health Care Spending Account does not terminate while you are on FMLA leave. If it does, the Plan will reimburse eligible claims only for the period the coverage was in effect.

Where a continuous FMLA leave spans two cafeteria Plan Years, you may make a mid-year election for the remainder of the Plan Year during which the continuous FMLA leave began. This mid-year election will apply only to the remainder of the Plan Year during which the continuous FMLA leave began. A new election will be necessary when a new Plan Year commences.

If you are on an approved leave of absence, which does not constitute leave for FMLA purposes, please contact the Plan Administrator for guidance on continuation of your coverage under the Plan during your absence from work.

Appeals of Coverage Termination

If your coverage is terminated and you believe the termination is an error, you may appeal the termination of coverage using the appeal procedures described under "Questions and Appeals" section of this Summary Plan Description.

If your Dependent Child's coverage is terminated at age 26 and you believe the termination is in error because the Child is eligible to continue coverage beyond age 26 as an incapacitated child, you may dispute the termination of coverage using the following claim and appeal procedures for claims requiring a determination of disability:

Initial Claim:

The claim decision will be made no more than 45 days after receipt of your properly filed claim by the Plan Administrator. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond the control of the Plan, that the notice identifies those matters, and gives the date by which a decision is expected to be made. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Plan Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to have your denial reversed and an explanation of why this material or information is needed;
- A description of the Plan's procedures for having your claim reviewed and the time limits applicable to those procedures;
- A statement of your right to bring a civil action in federal court under Section 502(a) of ERISA following a denial on appeal;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating your child and vocational professionals who evaluated your child, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in making the determination (without regard to whether the advice was relied upon in making the benefit determination) and/or any Social Security disability determination you presented to the Plan;
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your child's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Appealing Denial of Claim:

On any wholly or partially denied claim, you or your representative may file an appeal with the Plan Administrator for a full and fair review. Your appeal request must be in writing and be received by the Plan Administrator no later than the expiration of 180 days from the date you received your claim denial.

As part of your appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- You may submit written comments, documents, records, and other information relating to your claim.

The Plan Administrator's review of your appeal request shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

An appeal decision will be made no more than 45 days after the Plan Administrator receives your timely appeal. The time for decision may be extended for one additional 45-day period provided that, prior to the extension, you are notified in writing that an extension is necessary due to special circumstances and such notice identifies those circumstances and gives the date by which the Plan Administrator expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Plan Administrator receives your response to the request.

The individual reviewing your appeal shall give no deference to the initial claim decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Plan Administrator will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial claim decision, nor a subordinate of such individual.

The Plan Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your appeal is based on a new or additional rationale, the Plan Administrator will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your appeal, so that you will have a reasonable opportunity to respond prior to that date.

If the Plan Administrator grants your appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination on review will be in writing and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures;
- A statement describing your right to bring a civil action under Section 502(a) of ERISA following denial of the appeal and any applicable contractual limitations period that applies to your right to bring a civil action for benefits, including the calendar date on which the contractual limitations period expires;

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating your child and vocational professionals who evaluated your child, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in making the determination (without regard to whether the advice was relied upon in making the benefit determination) and/or any Social Security disability determination you presented to the Plan;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your child's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

Also, upon request, the Plan Administrator will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

Continuation of Health Coverage (COBRA)

COBRA HEALTH PLAN COVERAGE

Federal law requires the Employer to offer Employees and their Dependents the opportunity for a temporary extension of health coverage (called "continuation coverage" or "COBRA Coverage") at group rates in certain instances where coverage under the Plan would otherwise end. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. **You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

If coverage under this Plan would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment ending or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the Employee's employment stopping or work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under this Plan, subject to the following conditions:
  - The Qualified Beneficiary must provide the Employer or the designated COBRA Administrator with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
  - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
  - If the Qualified Beneficiary entitled to the additional 11 months of coverage has non-disabled family members who are entitled to continuation coverage, those non-disabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the health coverage would have stopped due to the Qualifying Event other than those described above.
- The date this Plan terminates.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date, after electing this continuation, that the Qualified Beneficiary becomes entitled to benefits under Medicare.
- The date, after electing this continuation, that the Qualified Beneficiary becomes covered under any other group health plan.
- If after the first Qualifying Event another Qualifying Event occurs, coverage can be continued for an additional period, for a total of 36 months from the date of the first Qualifying Event.
- For a Qualified Beneficiary of an Employee who lost coverage because of termination (or reduction of hours) within 18 months of becoming eligible for Medicare, 36 months from the date the Employee's eligibility for Medicare.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage.

Unless otherwise specified, an Employee or Spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. Your initial COBRA premium payment covers the time period from the date your coverage is lost to the date you elect Continuation of Coverage. Subsequent monthly payments are due on the first day of each month. If the initial payment is not made within 45 days of election or subsequent payments are not made within 30 days of the due date, COBRA coverage will terminate.

Notification Requirements

A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage or domestic partnership is dissolved.
- The Qualified Beneficiary becomes legally separated from their Spouse or Domestic Partner.
- The covered Employee reduced or eliminated their Spouse’s or Domestic Partner’s coverage in anticipation of their divorce or legal separation, and the anticipated divorce or legal separation has subsequently occurred.
- A Child stops being an eligible Dependent.

In the event of disability, the deadline for providing Notice of Disability is 60 days after the last of:

- The date of the Social Security Administration’s disability determination;
- The date of the covered Employee’s termination of employment or reduction of hours; and
- The date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of termination of employment or reduction of hours.

The Qualified Beneficiary should contact the T-Mobile Benefits Center at 1-855-TMO-BENS (855-866-2367).

COBRA Payments Only

T-Mobile USA
PO Box 850512
Minneapolis, MN 55485-0512

WARNING: IF YOUR NOTICE IS LATE, OR IF IT IS NOT COMPLETED AND PROVIDED TO THE EMPLOYER OR DESIGNATED COBRA ADMINISTRATOR AS DESCRIBED ABOVE, NO QUALIFIED BENEFICIARY WILL BE OFFERED THE OPPORTUNITY TO ELECT COBRA COVERAGE.

The designated COBRA Administrator will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

Special Second Election Period for Certain Eligible Employees Who Did Not Elect COBRA and Qualify for Trade Adjustment Assistance

Certain Employees and former Employees who lose coverage due to shifts in production, or increased imports from foreign countries, may be eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). As

part of this program, the Employee is entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special election period lasts for 60 days or less and begins on the first day of the month in which an Eligible Employee or former Employee qualifies for TAA or ATAA. The election must be made within six months after plan coverage ends. In addition, a 65% tax credit is available towards the cost of COBRA coverage.

Contact the Employer or designated COBRA Administrator promptly after qualifying for TAA or ATAA to ensure your right to elect COBRA during the special second election period. If you have any questions regarding this provision, contact the Employer or designated COBRA Administrator.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If You Have Questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the T-Mobile Benefits Center at 1-855-TMO-BENS (855-866-2367). For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SPECIAL TERMS THAT APPLY TO THIS CONTINUATION PROVISION

Qualifying Event

A Qualifying Event for the purposes of COBRA is any of the following, which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is dissolved.
- The Employee's Domestic Partnership ends.
- The Employee becomes legally separated from their Spouse.
- The Employee's Dependent stops being an eligible Dependent.

Qualified Beneficiary

Any of the following persons who are covered by the Plan on the day before a Qualifying Event:

- The Employee.

- An Employee's Spouse or Domestic Partner.
- An Employee's former spouse (or legally separated spouse).
- A Dependent Child, including a Child born to, adopted by, placed with for adoption, acquired through legal guardianship or a Child of the Domestic Partner of the Employee during a period of continued coverage.

COBRA SECTION 125 PLAN PARTICIPATION

Health Care Flexible Spending Account

If you terminate employment, you may elect to continue to participate in the Health Care Spending Account for the remainder of the Plan Year if you are eligible to continue your participation in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA's final regulations, if you have a positive balance in your account at the time of the qualifying event (after calculating incurred expenses to that point in time), you may continue in the Health Care Spending Account through the end of the plan year in which the qualifying event occurred. In this circumstance, continuation coverage for Health Care Spending Accounts will not be offered at open enrollment of any future plan year. If at the time of the qualifying event you have a negative balance in your account, COBRA continuation coverage will not be offered. Refer to the handbook or summary of your health benefits or to the COBRA notice provided by your Human Resources Department for a complete explanation of COBRA eligibility. ***NOTE:*** *An expense is "incurred" when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for or pays for the medical care.* If you elect COBRA continuation for your Health Care Spending Account and pay the required premiums, you will be able to request reimbursement for qualifying expenses you incur through the end of the current plan year. Your deadline for requested reimbursement is 120 days from the end of the plan year. As a result, the deadline to request reimbursement for qualified expenses for the plan year ending December 31st will be April 30th of each year. If you have unused Health Care FSA dollars at the end of the Plan Year, up to $680 will carry over to the next Plan Year. Amounts above $680 will be forfeited. The carryover will remain until the participant is no longer eligible for FSA through T-Mobile or COBRA, even if they do not re-enroll in the Plan for the following year. This carry over is in addition to the participants' new plan year election.

If you cease to be an Eligible Employee for reasons other than termination of employment, you may only continue to participate if you are eligible to elect COBRA (see above). In general, you will be eligible for COBRA because of a change of employment status only if you are no longer an Eligible Employee because your hours have been reduced below the level required for participation in the Plan.

If you continue your participation under COBRA, you will make your contributions on an after-tax basis (or pre-tax under certain circumstances, see note below) in accordance with procedures specified by the Plan Administrator. If you return to employment as, or once again become, an Eligible Employee while you are still participating, your payments will automatically resume on a pre-tax basis. If you are not eligible to or are eligible but do not elect to continue participation, you may receive reimbursement for eligible Medical Expenses which you incurred while a participant in the Plan, up to the total amount you elected for the Plan Year (minus prior reimbursements).

NOTE: *In general, you will be eligible to make pre-tax payments to your COBRA Health Care Spending Account because of a change of employment status only if:*

- *You remain an employee, but are no longer an Eligible Employee because you are no longer a Regular Full Time or Regular Part Time 1 Employee,*
- *You have a positive balance in your account at the time of the qualifying event,*
- *You are still employed by your current employer.*

Dependent Care Spending Account

If you terminate employment or cease to be an Eligible Employee for reasons other than termination of employment (for instance, due to a reduction of hours), you may receive reimbursement for any allowable employment-related Dependent Care Expenses incurred through the date of your termination, up to the amount in your Dependent Care Spending Account as of the date you ceased to participate. No additional contributions can be made to your Dependent Care Spending Account following your eligibility end date.

Coordination of Benefits (Medical, Dental, Vision)

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN

This section describes how Benefits under T-Mobile's group medical benefit plans will be coordinated with those of any other plan that provides benefits to you.

WHEN DOES COORDINATION OF BENEFITS APPLY?

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Once you become eligible for Medicare, coordination of benefits may change — see Effect of Medicare and Government Plans section below.

DEFINITIONS

For purposes of this section, terms are defined as follows:

Plan. A Plan is any of the following that provides benefits or services for medical, pharmacy, dental or vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1) Plan includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2) Plan does not include hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When

This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense. For the purposes of COB, an Allowable Expense is a health care expense, including deductibles, coinsurance, and copayments, that meets the definition of a Covered Health Service under This Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a Non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a Non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a Non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

Closed Panel Plan. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

WHAT ARE THE RULES FOR DETERMINING THE ORDER OF BENEFIT PAYMENTS?

Except as explained in the Effect of Medicare and Government Plans Section below, the Claims Administrator (Premera Blue Cross, UnitedHealthcare, Delta Dental of Washington or Vision Service Plan) is responsible for determining which plan is considered primary — and, therefore, which pays benefits first. As a rule, if a Covered Dependent child is the Patient, the plan covering the parent whose birthday comes earlier in the calendar year will pay first.

If there is a court decree that establishes financial responsibility for medical care of the child, the benefits of the plan that covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

- The benefits of a plan that covers the child as a dependent of the parent with custody will be determined before a plan that covers the child as a dependent of a stepparent or a parent without custody.
- The benefits of a plan that covers the child as a dependent of a stepparent will be determined before a plan that covers the child as a dependent of the parent without custody.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts the Claims Administrator needs from, or give

them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information the Claims Administrator needs to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

PAYMENTS MADE

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Claims Administrator may process This Plans' payment for that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

DOES THIS PLAN HAVE THE RIGHT OF RECOVERY?

If the amount of the payments This Plan made is more than This Plan should have paid under this COB provision, This Plan may recover the excess from one or more of the persons This Plan have paid, for whom This Plan have paid, or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

OVERPAYMENT AND UNDERPAYMENT OF BENEFITS

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future allowable expenses.

If the Plan overpays a health care provider, the Plan reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

REFUND OF OVERPAYMENTS

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- All or some of the payment the Plan made exceeded the Benefits owed under the Plan; or
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization (such as a provider) other than the

Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits that are payable to the person or organization in connection with services provided to other Covered Persons under the Plan. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

SUBROGATION AND RIGHT OF RECOVERY PROVISION

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian, or other representative of a Dependent Child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays Benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness, or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan’s subrogation and reimbursement interests are fully satisfied.

Subrogation And Reimbursement

The Plan has a right to subrogation and reimbursement. References to “you” or “your” in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

SUBROGATION—EXAMPLE

SUPPOSE YOU ARE INJURED IN A CAR ACCIDENT THAT IS NOT YOUR FAULT, AND YOU RECEIVE BENEFITS UNDER THE PLAN TO TREAT YOUR INJURIES. UNDER SUBROGATION, THE PLAN HAS THE RIGHT TO TAKE LEGAL ACTION IN YOUR NAME AGAINST THE DRIVER WHO CAUSED THE ACCIDENT AND THAT DRIVER'S INSURANCE CARRIER TO RECOVER THE COST OF THOSE BENEFITS.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved, or waived in writing.

REIMBURSEMENT—EXAMPLE

SUPPOSE YOU ARE INJURED IN A BOATING ACCIDENT THAT IS NOT YOUR FAULT, AND YOU RECEIVE BENEFITS UNDER THE PLAN AS A RESULT OF YOUR INJURIES. IN ADDITION, YOU RECEIVE A SETTLEMENT IN A COURT PROCEEDING FROM THE INDIVIDUAL WHO CAUSED THE ACCIDENT OR AN INSURANCE COMPANY. YOU MUST USE THE SETTLEMENT FUNDS TO RETURN TO THE PLAN 100% OF ANY BENEFITS YOU RECEIVED TO TREAT YOUR INJURIES.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury, or damages, or who is legally responsible for the Sickness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury, or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

By participating in the Plan and accepting Benefits under the Plan, you agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- The terms of this entire Subrogation and Right of Recovery Provision shall apply and the Plan is entitled to full recovery of the amount of Benefits paid, regardless of whether any liability for payment is admitted by the third party, and regardless of whether the settlement or judgment identifies the Benefits the Plan provided, or purports to allocate any portion of such settlement or judgment to payment of expenses other than the type of Benefits paid by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that if (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits — other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its prior written approval.
- The Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides prior written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Claims Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of Benefits paid by the Plan for the treatment of the illness, injury, or condition upon any recovery whether by settlement, judgment, or otherwise, related to treatment for any illness, injury, or condition for which the Plan paid Benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of Benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of Benefits paid by the Plan.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover Benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the Plan, or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all Benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Jurisdiction

By accepting Benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such Benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

EFFECT OF MEDICARE AND GOVERNMENT PLANS

Medicare

Medicare coverage is extended to persons turning age 65 or in various circumstances of entitlement to or eligibility for Social Security Disability or Railroad Retirement Board Benefits, including Lou Gehrig's Disease, and End Stage Renal Disease.

There are three parts to Medicare coverage relevant to your coverage under the Plan:

- Medicare Part A hospital insurance coverage is generally automatic and at no cost to you.
- Medicare Part B medical insurance coverage is always optional, meaning, you must sign up for it, and there is always a cost to you for Part B.
- Medicare Part D prescription drug coverage is also optional, and you must sign up and pay for it as well.

There are specified enrollment periods for optional Medicare coverage, and there is a premium penalty for failing to enroll within the applicable period.

Since there is a monthly premium for optional Medicare coverage, however, and many of the expenses under that optional Medicare coverage are covered by this Plan, you may wonder whether you should enroll in Medicare coverage. The answer to that depends on the Medicare rules and this Plan as described below.

For questions about Medicare, call Social Security's toll-free number (800) 772-1213, any business day from 7:00 a.m. to 7:00 p.m. or your local Social Security office.

WHAT IS DIFFERENT WHEN YOU QUALIFY FOR MEDICARE?

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Medicare rules do not require this Plan to remain primary for domestic partners and their children. At T-Mobile's election, however, this Plan will remain primary for any domestic partners or their children not covered by Medicare Part B or C.

This Plan's remaining primary does not delay the penalty-free enrollment period for those persons, so domestic partners and their children are encouraged to enroll in optional Medicare coverage during their enrollment periods.

Important! Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, even if the person has not enrolled in Medicare. If Medicare pays first, the Covered Person should enroll for both Parts A and B of Medicare when that Covered Person is first eligible and should use providers who accept Medicare. Otherwise, the Covered Person will be responsible for paying the portion of the cost of benefits that Medicare would have paid.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all the rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligible Covered Persons. It does not apply to any Covered Person unless that Covered Person becomes eligible for Medicare and Medicare is the Primary payer.

First, this Plan determines the amount payable according to the benefits under the Plan. However, the amount of Eligible Expenses is based on the amount of charges allowed under Medicare rules instead of the Reasonable Charges as defined by the Plan. Then, this Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference (if any) between Plan benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that would have been payable under Medicare when Medicare is Primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge — often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare — typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use Medicare's Allowable Expense or Medicare's limiting charge for covered services as the Allowable Expense for both the Plan and Medicare.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan that by law requires this Plan to pay Primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Medical Plans

Hawaii Employees — see separate Medical plan summaries provided by HMSA.

MEDICAL BENEFITS SUMMARY — PREMERA BLUE CROSS (PREMERA), SUREST, AND UNITEDHEALTHCARE (UHC)

IMPORTANT: *The Out-of-Area plans are available ONLY to those Employees identified by the Plan Administrator (and at the Plan Administrator's sole discretion) as living outside of the service areas for EPO, Health Savings Account (HSA) Plan and Health Reimbursement Account (HRA) Plans. It is NOT an additional plan choice.*

NOTE: *Your benefits may be paid at a higher level and your out-of-pocket expenses may be lower if you choose an in-network provider. For Premera Blue Cross, out-of-network charges are based on Allowed Amount.*

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to the respective medical administrator's section of this SPD.

Amounts which you are required to pay as shown below are based on *Eligible Expenses (UHC) / Allowed Amounts (Premera)* or, for specific Covered Health Services as described in the definition of Recognized Amount in the *Glossary*.

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
Plan Year Deductible ▪ 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 Expenses[12]; 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

[11] 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.

[12] For Premera, out-of-network charges are based on the Allowed Amount.

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
Copayments ▪ 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 ▪ 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: ▪ Deductibles ▪ Amounts above Eligible Expenses/Allowed Amounts ▪ Prior authorization penalty (see "Prior Authorization Requirement")	$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
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: ▪ 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.					

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
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 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:	▪ 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.			▪ 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).		
Prior Authorization Requirement 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.	▪ 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.			▪ 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.		
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 UHC 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	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: ▪ 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 To learn more about the personal health support programs, contact Customer Service at **1-866-358-2300**.					
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						
▪ Office Visits. ▪ Eye and Hearing examination (for diagnosis/treatment of a medical condition only).	PCP $25 – $130 office visit Specialist $25 – $130 office visit	PCP 100% after $35 copay Specialist 100% after $50 copay	60% after deductible	80% after deductible	60% after deductible	PCP 100% after $20 copay Specialist 100% after $30 copay

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
▪ 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.		Testing and Treatment 80%, no deductible				Testing and Treatment 80%, no deductible (Naturopaths covered out of network)
Physician Maternity Services ▪ 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 dependents under the T-Mobile plan definition. ▪ 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.	**Prenatal and Postnatal Care:** 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

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan** *No out-of-network benefits are available.*	**PPO with Health Reimbursement Account (HRA) Plan[11]** **IN-NETWORK**	 **OUT-OF-NETWORK[1]**	**High-Deductible Plan with Health Savings Account (HSA) Plan[11]** **IN-NETWORK**	 **OUT-OF-NETWORK[1]**	**Exclusive Provider Organization (EPO) Plan** *No out-of-network benefits are available.*
Newborn Care ▪ 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.	**Prenatal and Postnatal Care:** 100%, no copay Newborns who remain inpatient after mother's discharge are subject to a $3,500 Inpatient care copay	**Office Visit** PCP 100% after $35 copay Specialist 100% after $50 copay **Inpatient Care** 80% after deductible Inpatient well newborn is not subject to deductible	60% after deductible Inpatient well newborn is not subject to deductible	80% after deductible Inpatient well newborn is subject to deductible	60% after deductible Inpatient well newborn is subject to deductible	**Office Visit** PCP 100% after $20 copay Specialist 100% after $30 copay **Inpatient Care** 80% after deductible Inpatient well newborn is not subject to deductible
Preventive Care ▪ Well-childcare 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	**Office Visit / Prostate Exam** PCP and Specialist: 100%, no copay **Annual Flu Shot** 100%, no copay **Lab and X-ray** 100%, no copay **Routine Mammogram** 100%, no copay **Breast Pumps** 100%, no copay **Routine Colonoscopy** 100%, no copay	**Office Visit / Prostate Exam** PCP and Specialist: 100%, no deductible or copay **Annual Flu Shot** 100%, no deductible or copay **Lab and X-ray** 100%, no deductible or copay **Routine Mammogram** 100%, no deductible or copay **Breast Pumps** 100%, no deductible or copay **Routine Colonoscopy** 100%, no deductible or copay	**Office Visit / Prostate Exam** PCP and Specialist: 100%, no deductible or copay **Annual Flu Shot** 100%, no deductible or copay **Lab and X-ray** 100%, no deductible or copay **Routine Mammogram** 100%, no deductible or copay **Breast Pumps** 100%, no deductible or copay **Routine Colonoscopy** 100%, no deductible or copay	**Office Visit / Prostate Exam** PCP and Specialist: 100%, no deductible **Annual Flu Shot** 100%, no deductible **Lab and X-ray** 100%, no deductible **Routine Mammogram** 100%, no deductible **Breast Pumps** 100%, no deductible **Routine Colonoscopy** 100%, no deductible or copay	**Office Visit / Prostate Exam** PCP and Specialist: 100%, no deductible **Annual Flu Shot** 100%, no deductible **Lab and X-ray** 100%, no deductible **Routine Mammogram** 100%, no deductible **Breast Pumps** 100%, no deductible **Routine Colonoscopy** 100%, no deductible or copay	**Office Visit / Prostate Exam** PCP and Specialist: 100%, no deductible or copay **Annual Flu Shot** 100%, no deductible or copay **Lab and X-ray** 100%, no deductible or copay **Routine Mammogram** 100%, no deductible or copay **Breast Pumps** 100%, no deductible or copay **Routine Colonoscopy** 100%, no deductible or copay
Prescription Drug Coverage						
▪ Rx coverage provided by CVS	**Retail (30 days)**	**Retail (30 days)**	**Retail and Mail Order**	**Retail (30 days)**	**Retail and Mail Order**	**Retail (30 days)**

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
▪ 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 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.	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 **Weight Loss Medications (anti-obesity and anorexiants)** $100 copay maximum' **Mail Order / Retail (90 days)** Tier 1 (Generic): $20 copay Tier 2 (Preferred): $150 copay Tier 3 (Non-Preferred): $400 copay	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) 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 **Weight Loss Medications (anti-obesity and anorexiants):** $100 copay maximum **Mail Order / Retail (90 days)** 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)	Not covered	All tiers: 80% after deductible **Mail Order / Retail (90 days)** All tiers: 80% after deductible **Weight Loss Medications (anti-obesity and anorexiants):** Plan pays 80% after deductible	Not covered	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 **Weight Loss Medications (anti-obesity and anorexiants):** $100 copay maximum **Mail Order / Retail (90 days)** Tier 1 (Generic): $20 copay Tier 2 (Preferred): $70 copay Tier 3 (Non-Preferred): $120 copay
Hospital Services						

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan[11]		High-Deductible Plan with Health Savings Account (HSA) Plan[11]		Exclusive Provider Organization (EPO) Plan
	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.*
Emergency Care ■ 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-network provider will be determined as described in the medical administrators' section of the SPD. ■ Out-of-Area plans' coverage 80% after deductible	$600 copay (copay is waived if admitted)	80% after $200 copay and deductible (copay is waived if admitted)	80% after $200 copay and deductible (copay is waived if admitted)	80% after deductible	80% after deductible	80% after $200 copay and deductible (copay is waived if admitted)
Inpatient Care ■ 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 ■ 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						
■ Lyra Health — Part of the T-Mobile LiveMagenta Wellbeing Program ■ Up to ten Lyra care sessions per issue per year are available for each covered member at no cost. ■ Members can access care through livemagenta.lyrahealth.com or by calling 855-780-5958, with no access code required. ■ Lyra provides confidential, evidence-based mental health support — including therapy, coaching, family and child support, and substance use recovery resources. ■ Lyra Health replaced the prior Optum Employee Assistance Program (EAP) effective January 1, 2026, and continues as a key offering within the T-Mobile LiveMagenta wellbeing program						

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan[11]		High-Deductible Plan with Health Savings Account (HSA) Plan[11]		Exclusive Provider Organization (EPO) Plan
	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.*
Inpatient Mental Health ▪ 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 ▪ 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 ▪ 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 ▪ 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
Partial Hospitalization ▪ 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 ▪ 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 ▪ 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)

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
Allergy, Testing, and Treatment ▪ 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) ▪ 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 ▪ 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 ▪ 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 ▪ Rental of durable medical equipment not to exceed purchase price. ▪ Prosthetics include artificial limbs or eyes that are initial 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	$0 – $1,000 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan[11]		High-Deductible Plan with Health Savings Account (HSA) Plan[11]		Exclusive Provider Organization (EPO) Plan
	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.*
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 ▪ 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 ▪ 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 – $3,500 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 ▪ Limited to one device per ear every three years.	$250 – $500 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Home Health Care ▪ 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 ▪ Bereavement counseling for family members	Home: $70 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible

Premera (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan[11]		High-Deductible Plan with Health Savings Account (HSA) Plan[11]		Exclusive Provider Organization (EPO) Plan
	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.*
provided under the EAP plan, not the medical plan. ▪ No dollar or day limits. ▪ Patient must have life expectancy of 6 months or less.	Inpatient: $3,500 copay					
Infertility Benefits ▪ Fertility treatments are administered through Progyny. Please call (833) 281-0076 to activate benefits ▪ Diagnosis and treatment are both covered. ▪ Three (3) Smart Cycles per family (employee and spouse)	$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 ▪ 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 ▪ 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 (out-of-network providers are covered)
Mammogram ▪ Due to medical diagnosis. ▪ Routine mammograms are covered under Preventive Care.	$0 copay	100%, no deductible		100%, no deductible		100%, no deductible
Non-Preventive Nutritional Counseling ▪ Must be provided by dietician or nutritional counselor. ▪ Covered for chronic diseases only. ▪ Out-of-Area plans' coverage 80% after deductible.	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 (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
▪ Benefits for non-preventive nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.						
Nutritional Supplements / Enteral Feeding ▪ 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: ▪ 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	$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 (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	**Surest Copay Only Plan**	**PPO with Health Reimbursement Account (HRA) Plan[11]**		**High-Deductible Plan with Health Savings Account (HSA) Plan[11]**		**Exclusive Provider Organization (EPO) Plan**
	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.*
▪ 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.						
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) ▪ 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 ▪ Physical therapy (75 visits combined with OT). ▪ Occupational therapy (75 visits combined with PT). ▪ Speech therapy (75 visits/plan year max).	Physical Therapy: $15 – $90 copay Occupation Therapy: $15 – $115 copay	Office: 100% after $50 copay	60% after deductible	80% after deductible	60% after deductible	Office: 100% after $30 copay

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	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.*
▪ 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.	Speech Therapy: $15 – $115 copay					
Private Duty Nursing (Outpatient Only)	$70 copay	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible
Skilled Nursing Facility (Hospital or Free-standing) ▪ 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) ▪ 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. ▪ **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	$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 (Group #4022154) UHC (Group #222244) Surest (Group #78800721)	Surest Copay Only Plan	PPO with Health Reimbursement Account (HRA) Plan[11]		High-Deductible Plan with Health Savings Account (HSA) Plan[11]		Exclusive Provider Organization (EPO) Plan
	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.*
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.						
Urgent Care Center ▪ 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 ▪ **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%

With one of UHC's Virtual Visit providers, you can talk to a real, live, U.S. board-certified doctor or pediatrician on the phone or video chat 365 days a year, any time of the day or night. You can access this through MyUHC.com under the Find Care & Costs Tab > Virtual Care, or through the UHC App, in the Find Care section.

Premera Members have access to 98point6, an on-demand, video and text-based primary care. What it's for: Board-certified providers can answer questions, diagnose, and treat you when you're sick or if you have a chronic condition.

With Premera, for physical therapy there is Omada for Joint and Muscle Health. Video physical therapy you can do from anywhere — to diagnose and treat nearly all muscle and joint issues.

Go to **Find Care** on premera.com/T-Mobile to access these virtual care options.

UnitedHealthcare (UHC) Medical Plans

MEDICAL PLANS CLAIMS ADMINISTRATOR — CONTACT INFORMATION

UHC Member Services: 1-877-259-1527

UHC Website: http://www.myuhc.com

EPO (CHOICE NETWORK) OVERVIEW

This Plan pays for Covered Services and Supplies received from Choice Network Providers. In order to receive benefits under this Plan, referred to as the Network level, the Covered Person must receive care:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office; or
- At a Network Facility; or
- For Emergency Health Services; or
- For Urgent Care Center services.
- Benefits are not payable for covered Health Services that are provided by Non-Network providers, **except as designated in the Medical Benefits Summary.**

A Covered Person may call Member Services or check UHC's provider Website to determine which providers participate in the Choice Network.

UHC Member Services: 1-877-259-1527

UHC Online Provider Directory: http://www.myuhc.com

Prior Authorization Requirement

The Network Provider starts the prior authorization process for all medical care as outlined in the Prior Authorization section. For services that require prior authorization, **the Covered Person is not responsible for starting the prior authorization process if he or she receives care from a Network Provider**. This Plan pays Covered Services and Supplies at the Network level, as shown in the **Medical Benefits Summary**, if the Covered Person receives the care from a Network Provider.

No benefits are payable under this Plan for Covered Services and Supplies received from a Non-Network Provider.

Emergency Care

In an Emergency, any Emergency Care is payable at the Network level as shown in the **Medical Benefits Summary** regardless of whether the Covered Person receives services from a Network or Non-Network Provider. However, when the Emergency Care has ended, the Covered Person must receive care from a Network Provider before any additional services will be covered at the Network level. If the Covered Person does not receive services from a Network Provider, no benefits are payable.

Network Provider Charges Not Covered

A Network Provider contracts with UHC to participate in the Network. Under the terms of this contract a Network Provider may not charge a Covered Person or UHC for certain expenses, except as stated below. A Network Provider cannot charge the Covered Person or UHC for any services or supplies that are not Covered Health Services as determined by UHC.

If a Covered Person agrees with the Network Provider to pay any charges for services or supplies that are not Covered Health Services, these charges are not Covered Services and Supplies under the Plan and are not payable by UHC. The Covered Person will be solely responsible for these charges.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN AND HEALTH SAVINGS ACCOUNT (HSA) PLAN OVERVIEW

This Plan pays for Covered Services and Supplies received from either Network or Non-Network Providers. If Network Providers are used, this Plan pays a greater portion of Eligible expenses. This is called the Network level.

If Non-Network Providers are used, this Plan pays a lesser portion of Eligible expenses. This is called the Out-of-Network level.

A Covered Person may call Member Services or check UHC's provider Website to determine which providers participate in the Choice Plus network.

UHC Member Services: 1-877-259-1527

UHC Online Provider Directory: http://www.myuhc.com

Network Benefits

This Plan pays the Network percentage for Network Provider services as shown in the **Medical Benefits Summary**. See the **Medical Benefits Summary** for a complete description of any deductibles or copayments that may apply under this Plan.

Network Providers

The Claims Administrator or its affiliates arrange for health care providers to participate in a Network. At your request, the Claims Administrator will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call the Claims Administrator at the number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of T-Mobile or the Claims Administrator.

The Claims Administrator credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator. A directory of providers is available online at www.myuhc.com or by calling the telephone number on your ID card to request a copy. If you receive a Covered Health Service from a Non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to Non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing a Non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the Claims Administrator at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of the Claim Administrator's products. Refer to your provider directory or contact the Claims Administrator for assistance.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a Non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a Non-Network provider.

In this situation, your Network Physician will notify UnitedHealthcare and they will work with you and your Network Physician to coordinate care through a Non-Network Provider.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, Plan Highlights. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible, and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Non-Network Benefits apply to Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider, or Covered Health Services that are provided at a Non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Emergency Health Services provided by a Non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a Non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a Non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a Non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Network Provider Charges Not Covered

A Network Provider has contracted with UHC to participate in the Network. Under this contract a Network Provider may not charge the Covered Person or UHC for certain expenses, except as stated below. A Network Provider cannot charge the Covered Person or UHC for any services or supplies which are not Covered Health Services.

If a Covered Person agrees with the Network Provider to pay any charges for services or supplies that are not Covered Health Services, these charges are not Covered Services and Supplies under the Plan and are not payable by UHC. The Covered Person will be solely responsible for these charges.

Eligible Expenses

T-Mobile has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the Non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
- For Covered Health Services that are Ancillary Services received at certain Network facilities on a non-Emergency basis from Non-Network Physicians, you are not responsible, and the Non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are non-Ancillary Services received at certain Network facilities on a non-Emergency basis from Non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, you are not responsible, and the Non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
- For Covered Health Services that are Emergency Health Services provided by a Non-Network provider, you are not responsible, and the Non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are Air Ambulance services provided by a Non-Network provider, you are not responsible, and the Non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a Non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a Non-Network provider as described below, Eligible Expenses are determined as follows:

- For non-Emergency Covered Health Services received at certain Network facilities from Non-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Health Service Act with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state law All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the Non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a Non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Air Ambulance transportation provided by a Non-Network provider, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the Non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a Non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a Non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the Non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

When Covered Health Services are received from a Non-Network provider, except as described above, Eligible Expenses are determined as follows:

- An amount negotiated by the Claims Administrator;
- A specific amount required by law; or
- An amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan. (*Note: We could also separate this into two bullets*)

- Claims may be repriced by a third party utilized by UnitedHealthcare which could reduce your responsibility.

The Plan will not pay excessive charges. You are responsible for paying, directly to the Non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Employees (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Personal Health Support

This plan requires the use of Personal Health Support. Please see the **Personal Health Support** section for further information.

OUT-OF-AREA PLANS OVERVIEW

For those Employees identified as living outside of existing Provider network areas, T-Mobile offers Out-of-Area Plans. These plans will pay benefits as outlined in the **Medical Benefits Summary** to any licensed provider for Covered Health Services treatment.

Prior Authorization

Members must obtain prior authorization for all Covered Health Services that require prior authorization. Please see the Prior Authorization section for further information.

PERSONAL HEALTH SUPPORT — EPO, HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN, HEALTH SAVINGS ACCOUNT (HSA) PLAN AND OUT-OF-AREA PLANS

Care Management — Personal Health Support

UHC provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UHC may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number, so you can call them with questions about your conditions, or your overall health and well-being.

As of the publication of this SPD, the Personal Health Support program includes:

- **Admission Counseling.** Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Please call UHC Member Services at **1-877-259-1527** for support.
- **Inpatient Care Management.** If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management.** This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate, and reinforce discharge instructions, and support a safe transition home.
- **Risk Management.** Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management.** You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management.** You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call UHC Member Services at **1-877-259-1527**.

PRIOR AUTHORIZATION — EPO, HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN, HEALTH SAVINGS ACCOUNT (HSA) PLAN AND OUT-OF-AREA PLANS

Prior Authorization

When you or your provider seek prior authorization as required, UHC will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

EPO, HRA AND HSA PLANS: UNITEDHEALTHCARE REQUIRES PRIOR AUTHORIZATION FOR CERTAIN COVERED HEALTH SERVICES. NETWORK PRIMARY PHYSICIANS AND OTHER NETWORK PROVIDERS ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION BEFORE THEY PROVIDE THESE SERVICES TO YOU.

WHEN YOU CHOOSE TO RECEIVE CERTAIN COVERED HEALTH SERVICES FROM NON-NETWORK PROVIDERS, YOU ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION BEFORE YOU RECEIVE THESE SERVICES. NOTE THAT YOUR OBLIGATION TO OBTAIN PRIOR AUTHORIZATION IS ALSO APPLICABLE WHEN A NON-NETWORK PROVIDER INTENDS TO ADMIT YOU TO A NETWORK FACILITY OR REFERS YOU TO OTHER NETWORK PROVIDERS. SERVICES FOR WHICH YOU ARE REQUIRED TO OBTAIN PRIOR AUTHORIZATION ARE SHOWN BELOW.

OUT-OF-AREA PLAN: UNITEDHEALTHCARE REQUIRES PRIOR AUTHORIZATION FOR CERTAIN COVERED HEALTH SERVICES. YOU ARE RESPONSIBLE FOR OBTAINING AUTHORIZATION BEFORE YOU RECEIVE THE SERVICES. FOR DETAILED INFORMATION ON THE COVERED HEALTH SERVICES THAT REQUIRE PRIOR AUTHORIZATION, PLEASE REFER TO THE LIST BELOW.

Network facilities and Network providers cannot bill you for services they fail to prior authorize as required.

Services That Require Prior Authorization

You are required to obtain prior authorization for the following services:

- **Clinical Trials.** You must obtain prior authorization before participating in a clinical trial.
- **Neonatal Resource Services and Congenital Heart Disease.** You must obtain prior authorization before receiving services; and
  - You must call Progyny at (833) 281-0076 prior to receiving fertility treatment.
- **Transplantation Services.** You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).
- **Congenital Heart Disease (CHD) Surgeries.** For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.
- **Durable Medical Equipment (DME).** For Non-Network Benefits you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item).
- **Gender Identity Disorder.** For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises.
- **Home Health Care.** For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods, or as soon as is reasonably possible.
- **Hospice.** For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. In addition, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.
- **Hospital — Inpatient Stay.** For Non-Network Benefits, for a scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission. A non-scheduled admission, you must provide notification as soon as is reasonably possible. In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.
- **Lab, X-Ray.** For Non-Network Benefits for Genetic Testing, sleep studies, and stress echocardiography and transthoracic echocardiogram you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received.
- **Lab, X-Ray and Major Diagnostics — CT, PET Scans, MRI, MRA and Nuclear Medicine — Outpatient**. For Non-Network Benefits for CT, PET scans, MRI, MRA, nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received.
- **Maternity.** For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.
- **Mental Health — Substance-Related and Addictive Disorders, Neurobiological Disorders, Autism Spectrum Disorder Services.** For Non-Network Benefits for a scheduled admission for Mental Health, Substance-Related and Addictive Disorders, Neurobiological Disorders, and Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility and for Partial Hospitalization/Day Treatment/High Intensity Outpatient) you must obtain prior authorization from the Claims Administrator five business days before admission. For a non-scheduled admission, you must provide notification as soon as is reasonably possible. In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; outpatient electro-convulsive treatment; psychological testing; and transcranial magnetic stimulation.

- **Prosthetic Devices.** For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceeds $1,000 in cost per device.
- **Reconstructive Procedures.** For Non-Network Benefits for a scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedures is performed. A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible. In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.
- **Skilled Nursing.** For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission. A non-scheduled admission you must provide notification as soon as is reasonably possible. In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.
- **Surgery — Outpatient.** For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.
- **Therapeutic Treatments — Outpatient.** For Non-Network Benefits for the following outpatient therapeutic services, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound.

How to Obtain Prior Authorization

To obtain prior authorization, call UHC Member Services at **1-877-259-1527**. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs.

EPO and HSA and HRA Plans: Network providers are responsible for obtaining prior authorization from UHC before they provide certain Network services to you. EPO, HSA and HRA members must obtain prior authorization for the below non-network services.

Out-of-Area Plan: Members are required to obtain prior authorization for all services listed below.

The services requiring prior authorization are:

- Ambulance — non-emergent air;
- All inpatient admissions (except maternity) including acute hospital, rehabilitation facilities, skilled nursing facilities and hospice;
- Hospital Inpatient Stay — all elective admissions;
- All home-based services, including nursing services, respiratory, 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; female pelvic; foot; heart; knee/hip; rectum;
- Lab, X-Ray, and Diagnostics — Outpatient — sleep studies;

- Maternity admissions that exceed the federally mandated length of stay of 48 hours for vaginal or 96 hours for cesarean delivery;
- Organ and tissue transplant services (including evaluations);
- Surgery — Outpatient — sleep apnea surgeries and orthognathic surgeries;
- Therapeutic Treatments — Outpatient — all outpatient therapeutics;
- Breast Reconstruction, other than surgery following treatment for cancer (mastectomy); and
- Breast Reduction.

The ultimate decisions on medical care must be made by the Covered Person and their Physician. UHC only determines if the listed service or supply is a Covered Health Service according to the Plan benefits and provisions.

Prior authorization approval does not guarantee that benefits are payable under this Plan. Benefits are based on:

- The Covered Services and Supplies actually performed or given.
- The Covered Person's eligibility under this Plan on the date the Covered Services and Supplies are performed or given.
- Copayments, deductibles, coinsurance, maximum limits, and all other terms of this Plan.

When to Obtain Prior Authorization

- For inpatient confinement, prior authorization must be obtained prior to the scheduled admission date at least 5 working days before the start of the confinement. An admission date may not have been set when the confinement was planned. UHC must be contacted again as soon as the admission date is set.
- Pregnancy is subject to the following notification time periods:
  - Inpatient Confinement for Delivery of Child — prior authorization must be obtained from the UHC only if the inpatient care for the mother or Child is expected to continue beyond:
    - 48 hours following a normal vaginal delivery, or
    - 96 hours following a cesarean section.
  - For inpatient care (for either the mother or Child) which continues beyond the 48/96-hour limits stated above, prior authorization must be obtained from UHC before the end of these time periods.
  - Non-Emergency Inpatient Confinement without Delivery of Child — Confinement during pregnancy but before the admission for delivery, which is not Emergency Care, requires prior authorization as a scheduled confinement. Prior authorization must be obtained from UHC prior to the scheduled admission.
- For outpatient services, prior authorization must be obtained from UHC at least five working days before the service is given.
- Organ/Tissue Transplants, prior authorization must be obtained from UHC at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:
  - The evaluation
  - The donor search
  - The organ procurement/tissue harvest
  - The transplant

UHC will then complete a Review. The Covered Person, the Physician and the facility will be sent a letter confirming the results of the Review.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you

are required to travel to obtain such Covered Health Services from a Designated Provider UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

A Covered Person Can Appeal a Decision by Calling UHC

If the Covered Person or the Physician does not agree with UHC's decision, it can be appealed.

- The Covered Person or the Physician can request UHC to reconsider the decision by writing or telephoning within 60 days of the decision.
- If the Covered Person, the Physician and UHC still cannot find an acceptable solution, this decision can be re-appealed. Another Physician will review the facts of the case — taking into account the Covered Person's and the attending Physician's point of view — and make a final decision. If the Covered Person or the Physician does not agree with UHC's review decision, a Covered Person may request that the Claims Administrator review the decision.

Emergency Care

When Emergency Care is required and results in a confinement, the Covered Person (or that person's representative or Physician) must call UHC within two business days of the date the confinement begins. If the Covered Person is incapacitated, this requirement will be waived.

A working day is a business day of UHC. It does not include Saturday, Sunday or a State or Federal holiday. If it is not reasonably possible to call UHC within 48 hours, UHC must be notified as soon as reasonably possible.

When the Emergency Care has ended; however, UHC must be called before any additional services that require prior authorization are received.

MENTAL HEALTH / SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SUMMARY (ALL UHC PLANS)

Mental Health Services

The Mental Health Services Delegate (the Delegate) administers Benefits for Mental Health services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Services, you can contact the Delegate at the telephone number on your ID card.

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment;
- Residential Treatment;
- Partial Hospitalization/Day Treatment/High Intensity Outpatient;
- Intensive Outpatient Programs; and
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, and treatment and/or procedures;

- Medication management;
- Individual, family and group therapy; and
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator determines coverage for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating providers and coordination of care.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Applies to Non-Health Savings Account Plans — There are no Deductibles, Copayments or Coinsurance that you must meet or pay for when receiving these services.

Applies to Health Savings Account Plans — Except for the initial consultation, Covered Persons with a high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no Deductibles, Copayments or Coinsurance for the initial consultation.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Neurobiological Disorders — Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)* that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Programs.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.

- Individual, family, and group therapy.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

Substance Related and Addictive Disorder Services

The Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Substance-Related and Addictive Disorders Services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Services, you can contact the Delegate at the telephone number on your ID card.

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment;
- Residential Treatment;
- Partial Hospitalization/Day Treatment/Intensive Outpatient;
- Intensive Outpatient Programs; and
- Outpatient treatment.

Services include the following:

- Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).
- Diagnostic evaluations, assessment, and treatment and/or procedures;
- Medication management;
- Individual, family and group therapy; and
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for assistance in locating a provider and coordination of care.

Emergency Care

When Emergency Care is required for Mental Disorder or Substance Use Disorder Treatment, the Covered Person (or representative or Physician) must call UHC within 48 hours after the Emergency Care is given. UHC is ready to take calls 7 days a week, 24 hours a day. If it is not reasonably possible to make this call within 48 hours, the call must be made as soon as reasonably possible.

When the Emergency Care has ended, UHC must be called before any additional services are received.

Post Service (Non-Urgent) Appeals

A provider, member, or member's representative may request an appeal after a UHC determination that the benefit does not cover a requested service. UHC provides a two-level process for post-service appeals. Each level is completed in 30 days.

ADDITIONAL INFORMATION ABOUT YOUR MEDICAL BENEFITS

After coverage under this Plan stops, Medical Benefits are payable as shown in **Continuation of Health Coverage (COBRA)**.

Covered Services and Supplies for pregnancy are shown in **Pregnancy Benefits**.

Covered Services and Supplies for Mental Disorder Treatment are shown in **Mental Health Benefits/Substance-Related and Addictive Disorders** section.

Copayments and Deductibles

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

This Plan includes an Annual Deductible that applies to certain Covered Health Services. Refer to Medical Benefits Summary Section in this document, for details about the specific Covered Health Services to which the Annual Deductible applies.

The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear in Health Reimbursement Account (HRA) Plan and Health Savings account (HSA) Plan Overview and Additional Information About Your Medical Benefits

Office Visit Copayment (EPO and HRA Plan)

The Office Visit Copayment applies to Network Physician's Services as shown in the Medical Benefits Summary. It also applies to the following Network providers' services: physical therapists, occupational and speech therapists, licensed acupuncturists, chiropractors, naturopathic physicians, home health services, and outpatient and Substance Abuse Disorder counseling visits if the provider bills for their services separately from any other charges. It applies to all Covered Services and Supplies given in connection with each office visit.

The Office Visit Copayment does not apply to the prenatal (after initial diagnosis) and postnatal office visits to the Network obstetrician/gynecologist who is primarily responsible for maternity care.

Emergency Room Copayment (EPO and HRA Plan)

The Emergency Room Copayment applies to Hospital emergency room services. It applies to each emergency room visit. Emergency room services are payable only if it is determined that the services are Covered Health Services and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services. Emergency room services are covered for both emergency and urgent care. (See definitions of Emergency Care and Urgent Care.)

The Emergency Room Copayment does not apply if the Covered Person is admitted as a Hospital inpatient.

Urgent Care Center Copayment (EPO and HRA Plan)

The Urgent Care Center Copayment applies to Network Physician's Services given in a network walk-in urgent care center. A referral from the Covered Person's PCP is not required.

Individual Deductible

The Individual Deductible applies to all Eligible Expenses, or the Recognized Amount when applicable, except as shown in **Medical Benefits Summary**. It applies each Plan Year.

The actual amount that is applied to the Individual Deductible is calculated on the basis of Eligible Expenses or the Recognized Amount when applicable. The Individual Deductible does not include any amount that exceeds the Eligible Expenses.

Family Deductible

The most a family will have to pay for Individual Deductibles in any Plan Year is the amount of the Family Deductible. The Family Deductible applies no matter how large a family may be. Only Eligible Expenses, or the Recognized Amount when applicable that count toward a Covered Person's Individual Deductible count toward this Deductible. The family deductible is accumulative and must be met before the plan coinsurance applies for those with enrolled dependents (HSA Plan Only).

For the HSA plan, if you transfer mid-year from a Family HSA Plan to an Individual HSA Plan and there's no lapse in your coverage, any portion of the family deductible or out-of-pocket already satisfied will be credited up to but not exceeding the new plan deductible/out-of-pocket maximum amounts to your newly selected Individual HSA Plan.

NOTE: *Only expenses incurred to satisfy the deductible and out-of-pocket in the current calendar year will be credited.*

Coupons

The credits used on coupons or offers from pharmaceutical manufacturers or an affiliate will not apply to your Annual Deductible.

Plan Year Maximum Feature

Eligible Expenses are payable at the percentage shown in the **Medical Benefits Summary** until any Plan Year Maximum shown in the **Medical Benefits Summary** has been reached during a Plan Year. Then, Eligible Expenses are payable at 100% for the rest of that plan year as shown below.

All Eligible Expenses that the Covered Person pays, other than those shown below, count toward the Plan Year Maximum.

Individual Plan Year Maximum

When the Individual Plan Year Maximum is reached for any one Covered Person in a Plan Year, Eligible expenses, are payable at 100% for that same person for the rest of that plan year.

Family Plan Year Maximum

When the Family Plan Year Maximum is reached for all Covered Family Members in a Plan Year, Eligible expenses, are payable at 100% for all Covered Family Members for the rest of that plan year. The family deductible is accumulative and must be met before the plan coinsurance applies for those with enrolled dependents (HSA Plan Only)

For the HSA plan, if you transfer mid-year from a Family HSA Plan to an Individual HSA Plan and there's no lapse in your coverage, any portion of the family deductible or out-of-pocket already satisfied will be credited up to but not exceeding the new plan deductible/out-of-pocket maximum amounts to your newly selected Individual HSA Plan.

NOTE: *Only expenses incurred to satisfy the deductible and out-of-pocket in the current calendar year will be credited.*

Coupons

The credits used on coupons or offers from pharmaceutical manufacturers or an affiliate will not apply to your Annual Deductible.

Out-of-Network Coverage — Benefits for Treatment Received While Traveling

When you or your eligible dependents obtain non-emergency health care services while traveling in an area that does not have network providers, *or* while traveling out of the country, benefits will be reimbursed at the out-of-network benefit level.

If you or your eligible dependents have a medical emergency while traveling in an area that has no network providers, *or* while traveling out of the country, benefits will be provided at the in-network benefit level, subject to allowable charges, for covered services and supplies furnished by any covered provider.

NOTE: *If you are admitted to a medical facility outside of your network area, it is your responsibility to contact UHC Member Services at* ***1-877-259-1527****and notify them of your admission.*

For the purposes of benefit determination in this category, a medical emergency is:

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent person" is someone who has an average knowledge of health and medicine.)

- Examples of a medical emergency are severe pain, heart attack, and fractures.
- Examples of non-emergency care are minor cuts, scrapes, and colds.

COVERED SERVICES AND SUPPLIES

Covered Services and Supplies must be Covered Health Services and given for the diagnosis or treatment of an accidental injury or Sickness.

A Covered Person and their Physician decide which services and supplies are given, but this Plan only pays for the following Covered Services and Supplies which are Covered Health Services as determined by UHC.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Chemotherapy

Cochlear Implants

Covered health services for cochlear implants are subject to the following medical criteria:

- Diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination.
- Post-lingual sensorineural deafness in an adult.

Placement of a cochlear implant in the second ear is a covered health service when the second implant is expected to:

- Increase quality and localization of sound and
- Demonstrate improvement in discrimination tests and functions at 70-dB sound pressure level (SPL) speech detection threshold.

Hospital, surgical and therapy services due to cochlear implants are covered as any other medical condition.

Prior authorization must be obtained before treatment is rendered. Contact UHC Member Services at **1-877-259-1527** for details regarding prior authorization.

Contraceptive Drugs, Services and Devices

The following services:

- Voluntary sterilization by either vasectomy or tubal ligation, including reversal of voluntary sterilization by either vasectomy or tubal ligation;
- Norplant, IUD and Depo-Provera injections and devices; and
- Prescription contraceptives (see **Prescription Drug Benefits**).

Durable Medical Equipment

Durable Medical Equipment means equipment that meets all of the following:

- Ordered or provided by a Physician for outpatient use;
- It is for repeated use and is not a consumable or disposable item;
- It is used primarily for a medical purpose; and
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment.

Some examples of Durable Medical Equipment are:

- Cochlear implant devices;
- Delivery pumps for tube feedings (including tubing and connectors);
- Braces that stabilize an injured body part and braces to treat curvature of the spine, including necessary adjustments to shoes to accommodate braces;
- A standard hospital-type bed;
- Equipment to assist mobility, such as a standard wheelchair;
- Oxygen concentrator units and the purchase or rental of equipment to administer oxygen; and
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Shoe inserts, arch supports, and shoe orthotics when prescribed by a Physician.
- Shoes (standard or custom), lifts and wedges.
- Custom molded cranial orthotics (helmets), when prescribed by Physician.

Benefits are provided for a single unit of Durable Medical Equipment (example: one insulin pump) and repair of that unit.

Benefits also include dedicated speech generating devices and tracheoesophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician.

For Non-Network benefits, you must obtain prior authorization from UHC before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). UHC will decide if the equipment should be purchased or rented. To receive Network benefits, you must purchase or rent the Durable Medical Equipment from the vendor that UHC identifies.

At UHC's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three-year timeframe limitation. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Foot Care

Routine foot care, except when needed for severe systemic disease for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services. Routine foot care services that are not covered include:

- Cutting or removal of corns and calluses.
- Nail trimming, nail cutting or nail debridement.
- Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.
- Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease.

Hearing Aid

Audiologist consultation, fittings and molds for hearing aids, initial batteries, and ongoing repairs. Benefit maximum of one device per ear for each Covered Person every three years from date of purchase.

Home Health Care

Services received from a Home Health Agency are covered that are both of the following:

- Ordered by a physician.
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- It is ordered by a physician;
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively; and
- It is not Custodial Care.

UHC will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Services are limited to 120 visits each Plan Year. One visit equals four hours of skilled care services.

Hospice Care

Hospice care that is recommended by a Physician is covered.

Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.

The Physician must certify that the patient is terminally ill with six months or less to live.

For Non-Network benefits, you must obtain prior authorization from UHC five business days before receiving services.

Hospital Services — Inpatient Stay

Room and board in a Semi-private room (a room with two or more beds).

Services and supplies received during the inpatient stay.

For Non-Network benefits, you must obtain prior authorization from UHC as follows:

- For elective admissions: five business days before admission.
- For non-elective admissions: within one business day or the same day of admission.

Hinge Health Overview

Hinge Health covers the entire continuum of MSK care. From chronic pain sufferers and those considering surgical interventions to members looking to incorporate more movement into their day with the Hinge prevention program, this comprehensive solution meets the needs of T-Mobile's entire population. Hinge combines advanced technology with the expertise of a clinical care team, to align members with care that is personalized to meet their unique goals and improve their overall quality of life.

Hinge offers care for:

- Chronic — Treat the physical and behavioral aspects of chronic MSK pain
- Acute — Recover from a specific injury
- Pre-and post-surgery — Support rehabilitation when surgery is the best course
- High Risk — Provide specialized care for complex MSK needs
- Women's Pelvic Health — Improve pelvic health for women at all stages of life
- Prevention — Prevent future injury and improve health and wellness

Hinge's model surrounds the member with high-touch support that is proven to be engaging, powerful, and effective at driving clinical and financial outcomes.

Eligibility

To be eligible for the Hinge Health programs, you and your eligible dependents must meet each of the following requirements: (i) be enrolled in a medical plan with the Hinge Health benefit, (ii) be age 18 or older, (iii) be located in the United States, and (iv) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

Cost

If you are eligible, Hinge Health is offered at no cost to you.

Hinge Health Contact Information

If you have any questions regarding Hinge Health, email help@hingehealth.com or call (855) 902-2777.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

OTHER SERVICES AND SUPPLIES

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of their license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Benefits are limited to 30 treatments per plan year.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip, and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; and
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices;
  - Certain promising interventions for patients with terminal illnesses; and
  - Other items and services that meet specified criteria in accordance with our medical and drug policies;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - *Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and*
    - *Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.*
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must obtain prior authorization from UHC prior to participation in a Clinical Trial.

Congenital Heart Disease Services

Covered Health Services for Congenital Heart Disease (CHD) services when ordered by a Physician. CHD services may be received at a Congenital Heart Disease Resource Services program. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service and is not an Experimental or Investigational Service or an Unproven Service.

Prior authorization is required for all CHD services, including outpatient diagnostic testing, in utero services and evaluation, congenital heart disease surgical interventions, interventional cardiac catheterizations, fetal echocardiograms and approved fetal interventions.

The Copayment and Annual Deductible will not apply to Network Benefits when CHD service is received at a Congenital Heart Disease Resource Services program. The services described under Travel and Lodging below are Covered Health Services ONLY in connection with CHD services received at a Congenital Heart Disease Resource Services program.

CHD services other than those listed above are excluded from coverage, unless determined by UHC to be a proven procedure for the involved diagnoses.

Contact UHC Member Services at **1-877-259-1527** for information about CHD services.

You are eligible for a Transportation and Lodging Benefit (see Travel and Lodging section for additional details.) There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all travel and lodging expenses reimbursed under this plan.

Obtaining Prior Authorization

You must obtain prior authorization from UHC as soon as CHD is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed). Please see Prior Authorization section for additional details.

Emergency Health Services

Emergency health services are Covered Services. Stabilization or initiation of treatment must be provided by or under the direction of a physician. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Network benefits are paid for Emergency Health Services, even if the services are provided by a Non-Network provider.

- If you are confined in a Non-Network hospital after you receive Emergency Health Services, you must obtain prior authorization from UHC within two business days or on the same day of admission if reasonably possible. UHC may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so.

EPO: If you choose to stay in the Non-Network hospital after the date UHC decides a transfer is medically appropriate, benefits will not be available.

Health Reimbursement Account (HRA) Plan and Health Savings Account (HSA) Plan: If you choose to stay in the Non-Network hospital after the date UHC decides a transfer is medically appropriate, Non-Network benefits may be available if the continued stay is determined to be a Covered Health Service.

- If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services.

  NOTE: *The Copayment for Emergency Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the hospital. In this case, the Emergency Copayment will apply.*

Emergency Health Services are covered for both emergency and urgent care (see Medical Plan Glossary for definitions of Emergency and Urgent Care).

Gender Affirming Care

The Plan pays Benefits for the treatment of gender dysphoria (gender identity disorder) as follows:

- Psychotherapy for gender dysphoria and associated comorbid psychiatric diagnoses;

- Continuous hormone replacement — hormones of the desired gender;
- Surgery to change the genitalia and specified secondary sex characteristics, subject to medical appropriateness and the exclusions outlined below; and
- Laboratory testing to monitor the safety of continuous hormone therapy.

The Covered Person must meet all of the following eligibility qualifications for hormone replacement:

- Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks; and
- Either:
  - A documented real-life experience of at least three months prior to the administration of hormones; or
  - A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

The Covered Person must meet all of the following eligibility qualifications for genital surgery and surgery to change secondary sex characteristics:

- Age 18 years or older;
- Has completed 12 months of continuous hormone therapy for those without contraindications;
- Has completed 12 months of successful continuous full-time real-life experience in the desired gender; and
- Your Physician who is performing the surgery must notify Personal Health Support prior to performing the surgery.

The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender dysphoria (gender identity disorder).

Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure. Although not a requirement for coverage, UHC recommends that the patient complete at least 3 months of psychotherapy before having the mastectomy.

Voice therapy related to Gender Affirmation is covered and considered to be a type of speech therapy. Voice therapy may be considered medically necessary for gender transition/affirmation when ALL of the following criteria are met:

- Age 18 years or older;
- Diagnosis of gender dysphoria, confirmed by a physician, nurse practitioner, physician assistant, or Masters level mental health clinician.
- The participant is in the process of male to female or female to male transition/affirmation, confirmed by a physician, nurse practitioner, physician assistant, or Masters level mental health clinician.
- Voice therapy is provided by a qualified, licensed provider of speech language pathology services. A qualified provider is one who is licensed where required and performs within the scope of their licensure.

The parameters and guidelines of the type of care covered by T-Mobile USA, Inc.'s transgender benefits policy are based upon the World Professional Association for Transgender Health's (WPATH) standards of Care which are intended to provide flexible directions for the treatment of persons with gender dysphoria (GD). The general goal of psychotherapeutic, endocrine, or surgical therapy for persons diagnosed with GD is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.

Exclusions:

- Vaniqa (prescription cream to reduce unwanted facial hair);
- Services outside the U.S.

The Covered Person is eligible for a Transportation and Lodging Benefit (see Travel and Lodging section for additional details.) There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation and lodging expenses reimbursed under this Plan.

If you have questions about this benefit, please contact UHC Transgender Support Team by calling 1-800-326-9166 from 5:00 AM – 4:30 PM Pacific Time.

Injections Received in a Physician's Office

Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Laboratory Tests, Radiology and X-rays

Laboratory tests, radiology and x-rays for diagnosis or treatment. When these services are performed for routine care, benefits are as described under Preventive Health Care Benefits.

Medical Supplies

Disposable and surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.

Blood or blood derivatives only if not donated or replaced.

Medical Transportation Services

Transportation by professional ambulance, other than air ambulance, to and from a medical facility for life threatening conditions. Transportation to a medical facility by professional ambulance will also be covered if the participant would endanger himself or herself if this benefit was not utilized.

Transportation by regularly scheduled airline, railroad, or air ambulance, to the nearest medical facility qualified to give the required treatment. Coverage includes non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) between health care facilities when the ambulance transportation is any of the following as Plan Administrator determines to be appropriate: 1) From a Non-Network Hospital to a Network Hospital; 2) To a Hospital that provides a required higher level of care that was not available at the original Hospital; 3) To a more cost-effective acute care facility; 4) From an acute facility to a sub-acute setting.

Naturopath Physician

Covered Services are limited to 30 visits each Plan Year.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated United Resource Networks Facilities participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated United Resource Networks Facility is defined in the Medical Plan Glossary.

In order to receive Benefits under this program, the Network Provider must notify NRS or Personal Health Support if the newborn's NICU stay is longer than the mother's hospital stay.

You or a covered Dependent may also:

- Call Personal Health Support; or
- Call NRS toll-free at (888) 936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider.

Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

Non-Preventive Nutritional Counseling

The Plan covers non-preventive nutritional counseling services for mental health and substance-related and addictive disorders and medical diagnosis that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Nutritional Supplements / Enteral Feeding

Coverage for 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.

In addition, 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 or if sole source of nutrition.

Exclusions and limitations that apply to this benefit are in Medical General Exclusions and Limitations.

Obesity Treatment

Surgical

Surgical treatment of obesity is only available to covered Employees and Dependents who:

- Are age 12 or older;
- Completed and documented a 3-month supervised weight loss program prior to surgery;
- Have a BMI (body mass index) of 37.5 kg/m2 or greater; or have a minimum BMI of 32.5 kg/m2 with complicating comorbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity;
- Go through a United Bariatric Resource Network Center of Excellence facility; and
- Complete the pre-notification process prior to surgery through a United Resource Network Center of Excellence.

In order for services to be covered, you must participate in a program called Bariatric Resource Services where you will have access to a certain network of designated facilities and physicians participating in the Bariatric Resource Services Program for obesity surgery services. Services provided under this program include clinical consulting services to educate on treatment options and assist with the selection of a specialized network facility or physician.

You may contact Bariatric Resource Services by calling 888-936-7246. In order to receive Bariatric Resource Services benefits, you must contact Bariatric Resource Services and speak with a nurse consultant prior to obtaining Covered Health Services. Members 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 as part of the assessment.

Benefits under the Bariatric Resource Services program are subject to limitations and exclusions as described in this and other sections.

The lifetime maximum benefit for transportation and lodging (for all eligible services combined) is $10,000.

Travel and lodging expenses are only available if the patient resides more than 50 miles from the Bariatric Resource Services Facility. For further details, see Travel and Lodging section below.

Oral Surgery and Dental Services

Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.

Dental services for accidental injury are covered if all of the following are true:

- Treatment is necessary because of accidental damage that was sustained while coverage was in effect;

- Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."; and
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth, or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

The following services will be covered for accidental injury to natural teeth:

- Oral surgery;
- Facility charges incurred in connection with oral surgery;
- Patient is receiving full or partial dentures due to the accidental injury; and
- Patient requires repair to bridgework, if needed, due to accidental injury to the bridgework and/or natural teeth.
- The plan pays for treatment of accidental injury only for;
- Emergency examination;
- Necessary diagnostic x-rays;
- Endodontic (root canal) treatment;
- Temporary splinting of teeth;
- Prefabricated post and pre;
- Simple minimal restorative procedures (fillings);
- Extractions;
- Post-traumatic crowns if such are the only clinically acceptable treatment; and
- Replacement of lost tooth due to the Injury by implant, dentures, or bridges.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident; and
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident." Benefits are not available for repairs to teeth that are injured as a result of such activities.

Organ / Tissue Transplants

Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated United Resource Network Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service and is not an Experimental or Investigational Service or an Unproven Service.

Prior authorization notification is required for all transplant services.

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service;
- Heart transplants;
- Heart / lung transplants;

- Lung transplants;
- Kidney transplants;
- Kidney / pancreas transplants;
- Liver transplants;
- Liver / small bowel transplants, including CAR-T cell therapy for malignancies;
- Pancreas transplants; and
- Small bowel transplants.

Benefits are also available for cornea transplants that are provided by a Physician at a Hospital and will be paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Network Benefits.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by UHC to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact UHC at the telephone number on your ID card for information about these guidelines.

You are eligible for a Transportation and Lodging Benefit (see Transportation and Lodging section for additional details.) There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all travel and lodging expenses reimbursed under this Plan.

Orthognathic Surgery

Upper and lower jawbone surgery is covered as required for acute traumatic injury or cancer. When required for cancer, care of or treatment to the teeth, gums or supporting structures such as, but limited to periodontal treatment, endodontic services, extractions, dentures, implants, or any treatment to improve the ability to chew or speak are also covered. Medically necessary reconstructive Orthognathic Surgery is covered. Orthognathic services that are considered cosmetic are excluded.

Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician. Covered Services are limited to a lifetime maximum of 30 visits for each Employee or Dependent.

Physician Services

Covered Health Services include:

- Treatment of a Sickness or Injury;
- Preventive Care;
- Voluntary family planning;
- Well-baby and well-childcare;
- Routine well woman examinations, including pap smears, pelvic examinations, and mammograms;
- Routine well man examinations, including PSA tests;
- Routine physical examinations, including vision and hearing screenings (vision screenings do not include refractive examinations to detect vision impairment.);
- Immunizations;
- Medical Care and Treatment;
- Hospital, office, and home visits;
- Emergency room services;

- Surgery;
- Services for surgical procedures;
- Reconstructive Surgery;
- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
  - Birth defect;
  - Sickness;
  - Surgery to treat a Sickness or accidental injury; and
  - Accidental injury.
- Reconstructive breast surgery following a Covered Health Services mastectomy;
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury;
- Assistant Surgeon Services; and
- Multiple Surgical Procedures.

Multiple surgical procedures mean more than one surgical procedure performed during the same operative session.

Prescribed Drugs and Medicines

Prescribed drugs and medicines for inpatient services. See also **Prescription Drug Benefits** for information on outpatient prescription drugs.

Private Duty Nursing Care

Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

Prosthetic Devices

Prosthetic devices that replace a limb or body part including:

- Artificial limbs;
- Artificial eyes; and
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits will be provided for a single purchase, including repairs, of a type of prosthetic device.

At UHC's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Psychologist Services

See **Mental Health / Substance-Related and Addictive Disorders**

Radiation Therapy

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UHC at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedures. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, Glossary.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedures.

In addition, you must provide notification 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.

Rehabilitation Therapy

Inpatient

Please see benefit provisions under Skilled Nursing Facility / Inpatient Rehabilitation Facility Services.

Covered Services are limited to a total of 120 days of confinement in a Rehabilitation Facility each Plan Year.

Outpatient

Short-term outpatient rehabilitation services are covered for:

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Pulmonary rehabilitation therapy; and
- Cardiac rehabilitation therapy.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Covered Health Services that help a person with a medical or behavioral disabling condition to keep, learn, or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is provided to maintain a Covered Person's current condition or to prevent or slow further decline;
- It is ordered by a Physician and provided and administered by a licensed provider;
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively; and
- It is not Custodial Care.

UHC will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a medical or behavioral disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a medical or behavioral disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, or Physician; and
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, educational/vocational training, and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals is not a habilitative service.

The Plan may require the following be provided:

- Medical records.
- Other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under Durable Medical Equipment and Prosthetic Devices in this section.

Benefits are limited as follows:

- 60 combined visits of physical therapy and occupational therapy each plan year;
- 60 visits of speech therapy per plan year; and
- A combined maximum of 120 visits per plan year for speech, physical and occupational therapy due to congenital anomalies, developmental delay, cerebral palsy, and hearing impairment. No visit limit for autism (including characteristics of autism).

There is no benefit limit for cardiac and pulmonary rehabilitation therapy.

NOTE: *The Plan excludes any type of therapy, service, or supply for the treatment of a condition when the therapy, service, or supply ceases to be therapeutic treatment, and is instead administered to maintain a level of function or to prevent a medical problem from occurring or reoccurring.*

Skilled Nursing Facility / Inpatient Rehabilitation Facility Services

Services for an inpatient stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered. Benefits are available for:

- Services and supplies received during the inpatient stay; and
- Room and board in a semi-private room (a room with two or more beds).

Benefits are limited to 60 days per plan year for an inpatient stay in a skilled nursing facility.

Benefits are limited to 120 days per plan year for an inpatient stay in a rehabilitation facility.

Please note that, in general, the intent of skilled nursing is to provide benefits for Covered Persons who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).

Benefits are NOT available for custodial, domiciliary, or maintenance care (including administration of enteral feeds), which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene, or incontinence care, and checking of routine vital signs.)

Health Reimbursement Account (HRA) Plan and Health Savings Account (HSA) Plan: For Non-Network benefits, you must obtain prior authorization from UHC as follows:

- **For elective admissions** — five business days before admission.
- **For non-elective admissions** — within one business day or the same day of admission.

Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy

Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Services are covered for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Please note that the Plan excludes any type of therapy, service or supply including, but not limited to, spinal manipulations by a chiropractor or other Physician for the treatment of a condition when the therapy, service, or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Covered Services are limited to 30 visits each Plan Year.

Temporomandibular Joint Dysfunction (TMJ)

Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, development defect, or pathology.

This benefit covers:

- Exams
- Consultations
- Oral appliances and splints
- Trigger-point injections

- Treatment
- Surgical treatment if all other treatments have failed

Please note that benefits are not available for charges for services that are Dental in nature.

Exclusions and limitations that apply to this benefit are in Medical General Exclusions and Limitations.

Travel and Lodging Assistance Program

T-Mobile may provide you with Travel and Lodging assistance for the following categories:

- Congenital Heart Disease Services (CDH);
- Gender Affirming Care;
- Spina Bifida;
- Fertility Treatment;
- Hospice;
- Clinical Trials: Travel assistance for clinical trials (if not included with cancer treatment);
- Cancer Treatment;
- Mental Health/Substance Abuse;
- Cellular Immunotherapy and Gene Therapy;
- Reproductive Health Services;
- Obesity Treatment;
- Organ / Tissue Transplant; and
- Other covered medical or mental health treatment that requires traveling to or staying near a treating facility that is more than 50 miles from home.

Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

There is a combined $10,000 lifetime limit for all conditions eligible for travel and lodging assistance.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging assistance is covered in-network only unless it is for Gender Affirming Care.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion;
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered;
- Travel and lodging expenses are only available if the Covered Person lives more than 50 miles from the Designated Provider, and there are no other in-network providers within 50 miles who can perform the service; and

- Reimbursement for certain lodging expenses for the Covered Person and their companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

UHC must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The reimbursement limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be construed as tax advice.

Which Travel and Lodging transportation expenses are covered?

- Rental car and fuel
  - If your car rental receipt does not clearly show a daily rate, the rental bill will be divided by the total number of days of the rental to get a daily rate
- Personal car and fuel
- Mileage
- Domestic Airfare for economy/coach tickets
  - Domestic airfare other than economy or coach and international airfare is not reimbursable
- Train, bus, ferry, and subway fares
- Taxi, Uber, Lyft fares
  - Limos and car services are not covered
- Parking fee and tolls

Which Travel and Lodging expenses are not covered?

- Reimbursement is not available for (but is not limited to) the following:
  - Groceries
  - Meals/Beverages
  - Over-the-counter dressings, medical supplies
  - Personal care items or cleaning supplies
  - Phone calls, newspapers, movie rentals or other entertainment expenses
  - Tips
  - Other expenses not included under the covered items indicated as covered above

Urgent Care Center Services

Covered Health Services received at an Urgent Care Center are covered as indicated in the Medical Benefits Summary under Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, benefits are available as described under Physician's Office Services earlier in this section.

Virtual Care Services

Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

NOTE: *You may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.*

PREGNANCY BENEFITS

Benefits are payable for Covered Services and Supplies for pregnancy given to the Covered Person while covered under this Plan. These Covered Services and Supplies are listed in **Medical Benefits Summary.**

Benefits for pregnancy are paid in the same way as benefits are paid for Sickness except the Office Visit Copayment does not apply to prenatal and postnatal office visits (after the initial diagnosis) by the obstetrician/gynecologist who is primarily responsible for the patient's maternity care.

Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn Child following a normal vaginal delivery; and
- 96 hours of inpatient care for the mother and newborn Child following a cesarean section.

Health Reimbursement Account (HRA) Plan and Health Savings Account (HSA) Plan: Please remember that for Non-Network benefits, you obtain prior authorization from UHC as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the timeframes described above.

Federal law does not prohibit the mother’s or newborn’s attending Physician, after consulting with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as applicable).

Additional Covered Services and Supplies specific to pregnancy are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits Summary**.

Birth Center Services

- Room and Board;
- Other Services and Supplies; and
- Anesthetics.

Nurse-Midwife's Services

Services of a licensed or certified Nurse-Midwife.

Routine Well Baby Care

The following services and supplies given during a newborn Child's initial Hospital confinement:

- Hospital services for nursery care;
- Other Services and Supplies given by the Hospital;
- Services of a surgeon for circumcision; and
- Physician Services.

Exclusions and limitations that apply to these benefits are in Medical General Exclusions and Limitations.

FERTILITY SERVICES

Fertility treatments are administered through Progyny. Please call (833) 281-0076 to activate benefits.

Progyny administers T-Mobile's fertility benefits and offers comprehensive coverage to assist any member wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care. If you have any questions about your fertility benefit, please call your dedicated Progyny Patient Care Advocate, or you can call Progyny customer service at (833) 281-0076.

Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to):

- Artificial Insemination (IUI), Cryopreservation of oocytes and sperm
- FDA Bloodwork and Testing
- Fresh IVF Cycle
- Frozen Embryo Transfer (FET)
- Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer)
- IVF Freeze-All
- Patient Care Advocate (PCA) Concierge Support
- Pre-authorized fertility medications (via Progyny Rx)
- PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability
- PGT-M (PGD, or Pre-implantation Genetic Diagnosis)
- Pregnancy Gap Coverage (pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider)
- Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities), and the purchase of donor tissue (eggs and sperm)

Progyny's benefit has the following standard exclusions:

- Home ovulation prediction kits;
- Services and supplies furnished by an out-of-network provider or not listed as covered in the Progyny Member Guide;
- All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to laboratory tests, and
- Treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine.

PREVENTIVE HEALTH CARE BENEFITS

The Plan pays for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

In general, the Plan pays preventive care benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your Physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

Benefits are payable as shown in the **Medical Benefits Summary**. Examples of Covered Health Services for preventive care include:

Covered Services and Supplies

- Routine physical exam for covered Employees and Dependent Spouses, including diagnostic tests and immunizations. Limited to one per plan year.
- One flu shot each Plan Year.
- Routine well-woman exams. Limited to one per plan year in addition to a routine physical exam. A well-woman exam includes the following:
  - Breast examination and/or mammogram;
  - Pelvic examination; and
  - Pap smear.
- Routine well-man exams which include the following:
  - PSA laboratory test; and
  - Chromosome testing.
- Child preventive care services given in connection with routine pediatric care, including PKU tests and immunizations. Covered childhood immunizations generally include Diphtheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles-mumps-rubella (MMR), Conjugate Haemophilus influenza type B, Hepatitis B, Rotavirus vaccine, Varicella (Chicken Pox) and human papilloma virus (HPV) vaccine for ages 9-18.1
- Immunizations, including travel immunizations and HPV vaccine.
- Breast Pumps — the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.
  - Benefits are only available if breast pumps are obtained from a DME provider or Physician.
  - If more than one breast pump can meet your needs, benefits are available only for the most cost-effective pump. UHC will determine the following:
    - Which pump is the most cost effective;
    - Whether the pump should be purchased or rented;
    - Duration of a rental; and
    - Timing of an acquisition.

NOTE: *You may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit www.myuhc.com for additional information.*

Exclusions and limitations that apply to these benefits are in Medical General Exclusions and Limitations.

MEDICAL GENERAL EXCLUSIONS AND LIMITATIONS

This Plan will not pay or approve benefits for any of the services, supplies, items, or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies received before an Employee or their Dependent becomes covered under this Plan.

- Services or supplies received after the date an Employee or their Dependent's coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under this Plan. (An Employee may not be enrolled as both an Employee and a Dependent under the Plan.).
- A procedure or surgery to remove fatty tissue such as panniculectomy (except when medically necessary), abdominoplasty, thighplasty, brachioplasty, or mastopexy.
- Orthotic appliances and devices, except when all of the following are met:
  - Prescribed by a Physician for a medical purpose; and
  - Custom manufactured or custom fitted to an individual Covered Person.

    NOTE: *Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics, cranial bands, or any braces that are obtained without a Physician's order. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.*
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Chelation therapy, except to treat heavy metal poisoning.
- Any charges for completion of claim forms, missed appointments, room or facility reservations or record processing.
- Any charge for services, supplies or equipment advertised by the provider as free.
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency. Any charges prohibited by a federal anti-kickback or self-referral statues.
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
- Breast reduction surgery that is determined to be a Cosmetic Procedure, except those provided for Gender Affirming Care. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures.
- Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.
  - Care that meets one of these conditions is custodial care regardless of any of the following:
    - Who recommends, provides, or directs the care;
    - Where the care is provided; or
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Domiciliary care.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Experimental or Investigational Services and Unproven Services. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
  - This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials*

- Eyeglasses, contact lenses, eye refractions, unless required due to an accidental injury or cataract surgery (the Plan covers only the first pair of glasses or contact lens following cataract surgery). Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
- Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition.
- Health services for which you have no legal responsibility to pay and for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Herbal medicine, holistic or homeopathic care, including drugs, however the Covered Health Services of naturopathic physicians are covered services.
- Services, supplies, medical care, or treatment given by a family member by birth or marriage, including:
  - The Employee's Spouse; and
  - The Child, brother, sister, parent, or grandparent of either the Employee or the Employee's Spouse.

    NOTE: *This includes any service the provider may perform on himself or herself. This also includes in-laws and step relatives.*
- Services performed by a provider with the same legal residence.
- Services performed at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service; or
  - Is not actively involved in your medical care after the service is received.

    NOTE: *This exclusion does not apply to mammography testing.*
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided under *Reconstructive Procedures* or *Gender Affirming Care*.
- Surgical correction or other treatment of malocclusion. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or if required due to cancer. Orthognathic surgery and jaw alignment, except as treatment of obstructive sleep apnea. Medically necessary reconstructive Orthognathic Surgery is covered. Orthognathic services that are considered cosmetic are excluded. Services or supplies that are not Covered Health Services, including any confinement or treatment given in connection with a service or supply which is not Covered Health Services.
- Massage therapy, including any services provided by a Massage Therapist.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Medical and surgical treatment of excessive sweating (hyperhidrosis), except Botox.
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Snoring appliances.
- Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to Benefits provided under *Non-Preventive Nutritional Counseling*.

  NOTE: *Obesity-related nutritional counseling is covered as preventive.*
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

- For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, and hot tubs.
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career (except for vaccines or immunizations required for T-Mobile work-related travel), education, sports or camp, employment, insurance, marriage, or adoption;
  - Conducted for purposes of medical research; or
  - Related to judicial or administrative proceedings or orders unless Medically Necessary; or
  - Required to obtain or maintain a license of any type.
- Private duty nursing services while Inpatient.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
- Health services for organ and tissue transplants, except those described in **Other Services and Supplies**. Health services for transplants involving animal organs. Multiple organ transplants not listed as a Covered Health Service under Organ/Tissue Transplants under Other Services and Supplies, unless determined by the medical claims administrator to be a proven procedure for the involved diagnosis/diagnoses.
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under this Plan and is undergoing a covered transplant.
- Respite care; this exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under ***Hospice Care***.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* or elsewhere in this SPD.
- Stand-by services required by a Physician.
- Except as defined under **Orthognathic Surgery**, care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, orthodontia, extractions, implants, or any treatment to improve the ability to chew or speak. See **Other Services and Supplies** for limited coverage of oral surgery and dental services.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Special foods, food supplements, liquid diets, diet plans or any related products, unless allowed under the Nutritional Supplements/Enteral Feeding provision.
- Services for the evaluation and treatment of Temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances.
- Weight loss surgery for individuals under age 18.
- Weight loss treatment (except as a part of the Obesity Surgery benefit).
- Wigs or toupees (except for medically induced hair loss in all diagnosed situations), hair transplants, or hair weaving.
- Services given by volunteers or persons who do not normally charge for their services.

- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing, treatment of non-specific candida sensitivity and urine auto injections.
- Services provided to someone other than the ill or injured member. This includes health care provider training or educational services.
- Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*.
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Transitional Living services (including recovery residences).
- Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
- Residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment. Expenses for health services and supplies that exceed Eligible Expenses or any specified limitation in the SPD.
- Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider's license.
- Counseling, education or training in the absence of illness.
    - Job help and outreach, social or fitness counseling:
        - Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff.
        - Private school or boarding school tuition.
- Any health examinations required:
    - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement; or
    - By any law of a government.
- Growth/Height: Any treatment, device, drug, service, or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Any hearing service or supply that does not meet professionally accepted standards.
- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device.
- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies including: 1) annual or other charges to be in a physician's practice; 2) Charges to have preferred access to a physician's services.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).
- Non-medically necessary services, including but not limited to, those treatments, services and supplies which are not medically necessary, as determined by the medical claims' administrator, for the diagnosis and treatment of illness,

injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended, or approved by your physician or dentist.

- Over-the-counter hearing aids.

- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Sexual dysfunction/enhancement.
- Strength & Performance: Services, devices, and supplies to enhance strength, physical condition, endurance, or physical performance.
- Therapies and tests: Generally, any of the following treatments or procedures:
  - Aromatherapy;
  - Carbon dioxide therapy;
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
  - Massage therapy;
  - Megavitamin therapy;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Thermograms and thermography.
- Transplant: The transplant coverage does not include charges for:
  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services and supplies furnished to a donor when recipient is not a covered person;
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
  - Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing illness;
- Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by the medical claims administrator when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.
- Benefits are not provided for low-level laser therapy.
- Recreational, camp and activity-based programs. These programs are not medically necessary and include:
  - Gym, swim and other sports programs, camps and training;
  - Creative art, play and sensory movement and dance therapy;

- Recreational programs and camps;
- Hiking, tall ship, and other adventure programs and camps;
- Boot camp programs and outward-bound programs;
- Equine programs and other animal-assisted programs and camps; and
- Exercise and maintenance-level programs.

- Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-Network providers may not bill members for these services and members are held harmless.
  - Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
  - Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.
  - Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed on your Premera Blue Cross ID card or on the Centers for Medicare and Medicaid Services (CMS) Web page at www.cms.hhs.gov.
- This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.
- This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
- Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous.
- Health services and supplies that do not meet the definition of a Covered Health Service — see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
  - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
  - Medically Necessary.
  - Described as a Covered Health Service in this SPD under *Additional Coverage Details* and in *Plan Highlights*.
  - -Not otherwise excluded in this SPD under *Exclusions and Limitations*.
- 'Services or supplies, if provision of the services or supplies are illegal under the applicable state law where the services or supplies are provided.

HEALTH SAVINGS ACCOUNT — UNITEDHEALTHCARE

Introduction

This section describes some key features of the Health Savings Account (HSA) that you could establish to complement the Health Savings Account (HSA) Plan, which is a high deductible health plan.

T-Mobile USA, Inc. has entered into an agreement with UnitedHealthcare Services, Inc., Minnetonka, MN, ("UHC") under which UHC will provide certain administrative services to the Plan.

UHC DOES NOT INSURE THE BENEFITS DESCRIBED IN THIS SECTION. FURTHER, NOTE THAT IT IS THE PLAN'S INTENTION TO COMPLY WITH DEPARTMENT OF LABOR GUIDANCE SET FORTH IN FIELD ASSISTANCE BULLETIN NO. 2004-1, WHICH SPECIFIES THAT AN HSA IS NOT AN ERISA PLAN IF CERTAIN REQUIREMENTS ARE SATISFIED.

THE HSA DESCRIBED IN THIS SECTION IS NOT AN ARRANGEMENT THAT IS ESTABLISHED AND MAINTAINED BY T-MOBILE USA, INC. RATHER, THE HSA IS ESTABLISHED AND MAINTAINED BY THE HSA TRUSTEE. HOWEVER, FOR ADMINISTRATIVE CONVENIENCE, A DESCRIPTION OF THE HSA IS PROVIDED IN THIS SECTION.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible health plan described in this Summary Plan Description.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax-free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses; however, these amounts are subject to income tax and may be subject to 20 percent penalty.

You have three tools you can use to meet your health care needs:

- Health Savings Account (HSA) Plan, a high deductible health plan which is discussed in this Summary Plan Document/Plan Document;
- An HSA you establish; and
- Health information, tools, and support.

Benefits available under your medical plan are described in this Summary Plan Document.

WHAT IS AN HSA?

AN HSA IS A TAX-ADVANTAGED ACCOUNT T-MOBILE PARTICIPANTS CAN USE TO PAY FOR QUALIFIED MEDICAL EXPENSES THEY OR THEIR ELIGIBLE DEPENDENTS INCUR]. HSA CONTRIBUTIONS:

- Accumulate over time with interest or investment earnings;
- Are portable after employment; and
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible and How to Enroll

Eligibility to participate in the Health Savings Account is described in this Summary Plan Document for your high deductible health plan. You must be covered under a high deductible health plan in order to contribute to the HSA. In addition, you:

- Must not be covered by any high deductible health plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.);
- Must not participate in a full health care Flexible Spending Account (FSA);
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare); and
- Must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by T-Mobile USA, Inc. or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee (e.g., minimum deposit, balance, and distribution requirements; distribution timing requirements; account fees).

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

NOTE: *If coverage under a qualified high deductible health plan terminates, any further contributions made to the HSA will not qualify for the tax benefits applicable to HSAs.*

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) and remain HSA-eligible as of December 1 of that year, you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and remain HSA-eligible through December 31st of the following year or you will be subject to tax implications and an additional tax of 10%.

You may make an extra catch-up contribution of $1,000 annually, if you are 55 or older.

If you enroll in your HSA within the year (not on January 1) and remain HSA-eligible as of December 1 of that year, you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and remain HSA-eligible through December 31st of the following year or you will be subject to tax implications and an additional tax of 10%.

NOTE: *Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to the deadline for filing your federal income tax return (including any extensions) for the year the contributions were made.*

How Much Money Is Allocated to Your HSA — Employer Contributions

T-Mobile USA, Inc. may allocate a specified amount of funds to your HSA on a calendar Plan year basis specific to the coverage category you enroll in. The allocation will not exceed $500 for individual coverage and $1,000 for family coverage annually. Amounts are pro-rated per pay period. The table below contains the details for the employer contribution to your HSA:

Coverage Category	Per Pay Period Contribution to HSA
Employee	$19.23
Employee plus Spouse	$38.46
Employee plus Child(ren)	$38.46
Family	$38.46

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductible and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Carry Over Feature

If you do not use all of the funds in your HSA during the calendar plan year, the balance remaining in your HSA will carry over. If your employment terminates, you continue to own and control the funds in your HSA whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in this Summary Plan Document.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

IMPORTANT

BE SURE TO KEEP YOUR RECEIPTS AND MEDICAL RECORDS. SINCE HSA CONTRIBUTIONS ARE PRE-TAX, YOU CAN EITHER HAVE THE CONTRIBUTIONS DEDUCTED FROM YOUR PAYCHECK ON A PRE-TAX BASIS OR DEDUCT THE CONTRIBUTION AMOUNT FROM YOUR INCOME ON YOUR TAX RETURN SO THAT YOU DON'T END UP PAYING TAXES ON THE CONTRIBUTIONS. HOWEVER, IF YOU CANNOT DEMONSTRATE THAT YOU USED YOUR HSA TO PAY QUALIFIED HEALTH EXPENSES, YOU MAY NEED TO REPORT THE DISTRIBUTION AS TAXABLE INCOME ON YOUR TAX RETURN. T-MOBILE USA, INC. AND UHC WILL NOT VERIFY THAT DISTRIBUTIONS FROM YOUR HSA ARE FOR QUALIFIED HEALTH EXPENSES. CONSULT YOUR TAX ADVISOR TO DETERMINE HOW YOUR HSA AFFECTS YOUR UNIQUE TAX SITUATION.

THE IRS MAY REQUEST RECEIPTS DURING A TAX AUDIT. T-MOBILE USA, INC. AND THE CLAIMS ADMINISTRATOR ARE NOT RESPONSIBLE OR LIABLE FOR THE MISUSE BY PARTICIPANTS OF HSA FUNDS BY, OR FOR THE USE BY PARTICIPANTS OF HSA FUNDS FOR NON-QUALIFIED HEALTH EXPENSES.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UHC and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UHC provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify UHC and the financial institution in writing.

IMPORTANT NOTE FOR HSA ENROLLEES: Once you enroll in the HSA Plan with Premera or UHC, you may be asked to provide additional information before your HSA account can be opened. This is a requirement under federal law as part of the USA PATRIOT Act. If you have to provide additional information, you will be notified by Premera or UHC and allowed a period of time within which to respond. If you do not provide the requested information by the applicable deadline, your request to open an HSA account will need to be closed. This means you won't have an HSA to use for your out-of-pocket healthcare expenses. Any HSA contributions that were withheld from your pay, or employer HSA contributions that were scheduled to be made by T-Mobile, won't be available in an HSA for you. The HSA contributions that were withheld from

your pay will be returned to you as taxable income, and HSA contributions will stop being withheld from your pay. In addition, any T-Mobile employer HSA contributions that were scheduled to be made will be forfeited. However, if at some point in the future you request to reopen your application to open your HSA account, you will need to elect to restart both the T-Mobile employer and your individual HSA contributions to be withheld from your pay beginning within 1-2 pay periods from the request. Your own HSA contributions and T-Mobile's employer HSA contributions will only be made on a prospective basis once you have provided the information required to open your HSA account and your HSA account has in fact been officially opened. For help with any HSA-related questions: Premera enrollees contact (866) 358-2300 and UHC enrollees contact (877) 259-1527.

YOU CAN OBTAIN ADDITIONAL INFORMATION ON YOUR HSA ONLINE AT WWW.IRS.GOV. YOU MAY ALSO CONTACT YOUR TAX ADVISOR. PLEASE NOTE THAT ADDITIONAL RULES MAY APPLY TO A DEPENDENT'S INTENT TO OPENING AN HSA.

HEALTH REIMBURSEMENT ACCOUNT PLAN — UNITEDHEALTHCARE

This Section describes the healthcare expense reimbursement component of the Plan. It includes summaries of:

- What is a Health Reimbursement Account (HRA) Plan; Who is eligible and how to enroll; and How the HRA Plan works;
- New Hires and Adjustments for Status Changes;
- What Type of Expenses Qualify for Reimbursement from the HRA;
- What Happens to Remaining Balances in Your HRA;
- HRA Claims Procedures; and
- HRA Administrative Information.

This Section of the Summary Plan Description (SPD) describes the Employer-sponsored Health Reimbursement Account (HRA) Plan.

T-Mobile USA, Inc. has entered into an agreement with UnitedHealthcare Services, Inc., Minnetonka, MN, ("UHC") under which UHC will process eligible healthcare expense reimbursements through the HRA and provide certain other administrative services pertaining to the Plan. UHC does not insure the benefits described in this Section.

QUICK REFERENCE BOX

- Member services and claim inquiries, use the Customer Service number on the back of your ID card or call 1-800-331-0480;
- HRA Claims submittal address:
  Health Care Account Service Center, PO Box 981506, El Paso, TX 79998-1506; and
- Online assistance: www.myuhc.com.

A Health Reimbursement Account is a financial account that allows T-Mobile USA, Inc. to reimburse you for "qualified" health expenses paid by you, under the associated medical plan, to offset health care costs.

The HRA maximizes the value of your health care dollars and allows you to become more engaged in managing health care spending. UHC offers several tools to help you make more informed health care decisions and manage your HRA account balance. Visit www.myuhc.com for access to a treatment cost estimator. Once you spend your entire HRA balance, you are responsible for paying expenses as described in this SPD.

YOU CAN KEEP TRACK OF THE FUNDS IN YOUR HRA BY GOING ONLINE TO WWW.MYUHC.COM, BY CALLING THE TOLL-FREE NUMBER ON THE BACK OF YOUR ID CARD OR BY CHECKING YOUR MONTHLY MEMBER STATEMENT SENT TO YOU BY UHC.

Please read this Section thoroughly to learn how the HRA component of the Plan works. If you have questions call the number on the back of your ID card.

What Is a Health Reimbursement Account?

Health Reimbursement Accounts are "unfunded" accounts; otherwise known as a demand deposit accounts. T-Mobile USA, Inc. is not required to prepay into it, instead, funds allocated to the HRA are made available to reimburse you for claims as they occur. All contributions allocated to your HRA are owned, controlled and payable solely from the general assets of T-Mobile USA, Inc. You are not permitted to make any contribution to the HRA. In addition:

- The HRA is established by T-Mobile USA, Inc. and administered by UHC in accordance with applicable provisions of the Internal Revenue Service Code and associated guidance issued by the IRS/Treasury Department;
- T-Mobile USA, Inc. determines which Internal Revenue Code 213(d) health expenses will be eligible for reimbursement through the HRA;
- There is no limit to the contributions T-Mobile USA, Inc. can choose to allocate to your account;
- Employer contributions allocated to your HRA can be excluded from your gross income; and
- T-Mobile USA, Inc. will decide how to handle unused funds at the end of the calendar Plan year. Unused funds are not eligible for transfer outside of T-Mobile USA, Inc. accounts if your employment with T-Mobile USA, Inc. ends.

Who Is Eligible for the HRA and How to Enroll?

You must be covered under a medical plan sponsored by T-Mobile USA, Inc. and administered by UHC in order to participate in the HRA. You are enrolled in the HRA at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to participate in the Plan is described in this Summary Plan Document. Each year during Open Enrollment, you have the opportunity to review and change your benefit election. Any changes you make during Open Enrollment will become effective as described in this Summary Plan Document.

Cost of Coverage

You and T-Mobile USA, Inc. share in the cost of the medical plan. There is no additional charge to you for participation in the HRA component of your medical plan. Your contribution amount (also known as a premium) depends on the medical plan you select and the family members you choose to enroll.

Your medical plan premium is deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld — and in most states, before state and local taxes are withheld. For more information on the Cost of Coverage, please refer to this Summary Plan Document under the heading *Cost of Coverage.*

Changing Your HRA Coverage

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period, coverage will become effective as described in this Summary Plan Document under the heading *Qualifying Family Status Change Events*.

For detail on the employer contribution to your HRA for mid-year enrollment and/or status changes see this Section — *Health Reimbursement Account* under heading How the HRA Works and look for "New Hires and Adjustments for Status Changes".

For information on ending your coverage please refer to this Section — *Health Reimbursement Account*, under the heading *Termination of Coverage*.

How the HRA Works

How much money is allocated to your HRA — Employer Contributions

T-Mobile USA, Inc. may allocate a specified amount of funds to your HRA on a calendar Plan year basis specific to the coverage category you enroll in. The full amount is funded on your first day of coverage. For each claim presented to the HRA, available funds will be used to pay for your HRA Eligible Expenses. The table below contains the details for the Employer contribution to your HRA:

Coverage Category	Annual Employer Contribution to HRA (please see notes below for pro-ration rules)
Employee	$500
Employee plus Spouse	$1,000
Employee plus Child(ren)	$1,000
Family	$1,000

New Hires and Adjustments for Status Changes

New Hires

If you are hired during the Plan year or are enrolling in the Plan during a special enrollment period as a result of a change in status, the amount of the Employer contribution allocated to your HRA may be prorated.

The above contributions are prorated to $41.66 per month for Employee only coverage or $83.33 per month of coverage for all other coverages. The entire amount is available in your account on day 1 of enrollment.

Example 1: Employee's coverage is effective on October 1, and employee enrolls in Employee coverage category. An amount equal to $124.98 ($41.66 times 3) will be credited to employee's HRA account on October 1.

Example 2: Employee's coverage is effective on October 28, and employee enrolls in Employee coverage category. An amount equal to $124.98 ($41.66 times 3) will be credited to employee's HRA account on October 28.

Status Changes

When you switch among coverage categories, T-Mobile USA, Inc.'s contribution amount allocated to your HRA may increase or decrease by category.

Under the Plan, if you increase your category (e.g., self to self plus family) the employer contribution to your HRA will be adjusted to your new category for those remaining months of the Plan year. If you decrease your category (e.g., you change from self plus family to self) the employer contribution to your HRA will not be adjusted and will remain at the same level prior to your new category for the remaining months of the Plan year.

Example 1: Employee enrolls in employee only coverage on the HRA plan effective January 1. T-Mobile funds $500 to the HRA on January 1. The employee adds a spouse to the plan effective September 1. T-Mobile will fund an additional $166.64 to the HRA for employee and spouse coverage (pro-rated funding for the higher category for September, October, November and December).

Example 2: Employee enrolls in family coverage on the HRA plan effective January 1. T-Mobile funds $1,000 to the HRA on January 1. The employee removes their spouse and child from the plan effective October 1. No adjustments will be made to remove any funding; funds will remain as though there was no change.

Reinstatement of former participant: Subject to the Special Rules noted above, if you terminate employment or cease to be an Eligible Employee and are rehired or return to status as an Eligible Employee during the same Plan Year in which you terminated or ceased to be eligible, and the rehire or return to status occurs within 30 days of the termination or cessation, you are required to participate for the remainder of the Plan Year by continuing your original election for that Plan Year on a pro

rata basis. If you are rehired within 30 days in a different Plan Year, a new enrollment opportunity is provided. The effective date of coverage is the first of the month following date of rehire. If more than 30 days pass (but less than 13 weeks pass) and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following date of rehire. If 13 weeks or more pass, and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following 30 days of continuous employment after date of rehire.

You can keep track of the funds in your HRA by going online to www.myhc.com, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UHC.

What Type of Medical Expenses Qualify for Reimbursement from the HRA

Not all health-related expenses qualify for reimbursement under the HRA Plan. Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time defines what health care expenses are considered "qualified" medical expenses for federal income tax purposes. Only amounts that are paid specifically to reimburse eligible medical care expenses, as defined in Section 213(d), will be covered under the HRA Plan. T-Mobile has determined which of those "qualified" medical expenses will be considered HRA Eligible Expenses under your Plan and reimbursable from your HRA.

Under your Plan, the HRA reimburses all amounts due from claims for medical expenses that are eligible from the underlying medical plan, plus any claims for pharmacy expenses. Allowable expenses include Annual Deductible, Coinsurance and Copayments.

What Happens to Remaining Balances In Your HRA

If you don't spend all the funds in your HRA during the initial calendar Plan year, and you re-enroll in the Plan for the following year, any remaining HRA balance rolls over into your account for the next calendar Plan year. In this manner your HRA may "grow" almost like a savings account. The total amount in your HRA is limited to $6,000, any funds over this amount are forfeited.

When you are no longer enrolled in the Plan, you forfeit any unused funds remaining in the account.

HRA Account Balance Transfers

T-Mobile USA, Inc. may allow for balance transfers in cases where both spouses are T-Mobile USA, Inc. employees and one spouse terminates their employment with T-Mobile USA, Inc. Upon request, balance transfers will be granted from one employee spouse to another, remaining, employee spouse upon termination. This transfer will be contingent on the terminating spouse waiving HRA COBRA rights.

Upon death of an active T-Mobile, USA, Inc. employee balance transfers and continuance of reimbursement of expenses to dependent spouse and children will be permitted. The HRA is subject to COBRA as detailed in this Plan Document. Upon a COBRA-qualifying event — such as death of the employee — spouses and children, as independent qualified beneficiaries, may elect to continue the same coverage that was in effect on the date of the event with the HRA funds balance.

Balance transfers will not be permitted to cash or taxable benefit upon the death, termination, or other cessation of coverage under the HRA.

Health Care Spending Card Debit MasterCard®

The Health Care Spending Card Debit MasterCard® is a payment mechanism that allows members a means for direct payment of HRA Eligible Expenses, per your specific plan design, to UHC network providers, Drugstore.com, Walgreen's and participating merchants. Payment for HRA Eligible Expenses will come directly from your HRA and eliminates the need for you to submit most paper claims.

You will be provided with one Health Care Spending Card Debit MasterCard®, with terms and conditions and activation information that may be used at certain locations where MasterCard® is accepted. Contact the customer service number listed on the back of the Health Care Spending Card Debit MasterCard® with questions or to request additional cards.

Use of the Health Care Spending Card Debit MasterCard® is voluntary. The card must be activated prior to use. To activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. When you activate the Health Care Spending Card Debit MasterCard®:

- Prior to the plan effective date, wait one (1) business day after the plan effective date before you utilize your card; or
- After the plan effective date, the card will be ready to use one (1) business day following activation.

If you decide not to activate the Health Care Spending Card Debit MasterCard®, simply destroy and discard both cards. However, you can be reimbursed for HRA Eligible Expenses by completing a paper reimbursement form available from T-Mobile USA, Inc. or found on www.myuhc.com and as described under this Section — under the heading Requesting a Reimbursement from Your HRA or for HRA Eligible Expenses by using the automatic reimbursement (auto-submission) feature described under this Section — under the heading *Claims Submission*.

The Internal Revenue Service may require that you provide a receipt, statement, or Explanation of Benefits for certain HRA Eligible Expenses that have already been reimbursed through your card in order to prove that the services received were for qualified medical expenses incurred within the plan year, as defined by T-Mobile USA, Inc. in this SPD. You will be notified through a letter if you need to provide such information. If UHC does not receive the required documents as described in the letter, your card will be inactivated in accordance with applicable IRS regulations and guidelines. If UHC determines that the claim was not for a qualified medical expense as described in the letter this will be considered an overpayment to you and UHC will automatically withhold the payment of future claims until the full amount of the overpayment is received. If your card is inactivated due to the payment of an ineligible expense or the lack of documentation as described in your letter, we will activate your card upon receiving the requested documentation or the payment in full of any outstanding overpayment(s).

UHC Network Providers and Participating Merchants

The consumer website, www.myuhc.com, contains a directory of medical, dental and vision providers in UHC's provider network. While network status may change from time to time, www.myuhc.com has the most current source of provider network information. Use www.myuhc.com to search for network providers available in your specific plan design.

Participating drug store and pharmacy merchants comply with specific methods used to identify and substantiate eligible expenses, per the United States Internal Revenue Code of 1986 ("IRC"), as amended from time to time. You can see a full list of participating merchants at http://www.sig-is.org. Participating merchants identify what is an eligible expense under 213(d) of the IRC, they do not identify eligible HRA expenses at point of sale based on your specific plan design.

Using the Health Care Spending Card Debit MasterCard®

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS; therefore, you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard® because certain payments must be verified and UHC may request this receipt from you to ensure that payment was made for an HRA Eligible Expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design. A claim number is assigned to the transaction.

Qualified Locations and Providers

The Health Care Spending Card Debit MasterCard® may not be used at point of sale to make a purchase from non-participating merchants. You will need to pay using another form of payment, and then submit eligible expense receipts for reimbursement as described under the Section — *Requesting Reimbursement from your HRA*.

The Health Care Spending Card Debit MasterCard® may be used for a point-of-sale purchase at any UHC network provider or participating merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® such as a network hospital, network physician and retail network pharmacy counters.

You may choose to use your Health Care Spending Card Debit MasterCard® for mail order prescriptions by going to an online pharmacy at Drugstore.com via www.myuhc.com. Additionally, your Health Care Spending Card Debit MasterCard® can be used at Walgreen's retail stores or at participating drug store and pharmacy merchants.

No Personal Identification Number ("PIN") is required when you use the Health Care Spending Card Debit MasterCard®. At the point of sale choose 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your HRA and card are regulated by the Internal Revenue Service,

therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard®. Certain payments must be verified and UHC may request this receipt from you to ensure that payment was made for a qualified HRA expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases in real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design. A claim number is assigned to the transaction.

Partial Payment Authorization

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® with transactions amounts greater than the funds available in your HRA for a portion of the transaction at merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HRA, the HRA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment.

NOTE: *Not all merchants accept partial authorization.*

Member Health Statements and HRA Yearly Statements

Member Health Statements are available on the consumer website, www.myuhc.com. Member health statements are produced whenever there is claims activity for a member. You will receive monthly health statements and a yearly HRA statement which will include your card activity. If you note a discrepancy with a card transaction, call the number on the back of your Health Care Spending Card Debit MasterCard® to resolve the issue.

HRA Claim Procedures

Claims Submission

T-Mobile USA, Inc. has designed your HRA to allow certain claims to be automatically submitted to your account for reimbursement. UHC will coordinate payments from your HRA for medical claims and pharmacy claims. You can turn this feature "off" or back "on" via www.myuhc.com. 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. Also, if you turn "off" this feature or turn it back "on," the change is processed prospectively.

There are some types of claims that will not be processed automatically for which you will need to submit a claim manually; for additional information on these claims see the header below called When to Submit a Claim.

When auto-submission is elected all reimbursements from the HRA will be sent directly to the provider, exceptions are listed below. When no provider information is available the reimbursement will be sent to you. In the five exception situations listed below, the reimbursement from the HRA will go directly to you and not the provider:

- Pharmacy claims;
- Copays;
- Manually submitted claims (paper claims you submit directly);
- Non-network provider claims; and
- Claims adjustments.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UHC will process the payment for the medical plans portion of the cost of the Covered Health Services and send it directly to the Physician or facility.

Funds allocated to your HRA will be available to help you pay a portion of your out-of-pocket costs under the medical plan as described in this Summary Plan Document in Section — How the HRA Works. UHC will process the payment for a portion of your cost of the Covered Health Services from available funds in your HRA and send it directly to the Physician or facility automatically. This feature can be turned on and off by accessing www.myuhc.com. There are some types of claims that will

not be paid directly to the provider they are as follows: Pharmacy Claims, Copays, manually submitted claims, and adjustments and out-of-network provider claims. These types of claims will always pay you directly.

Non-Network Benefits

If you receive a bill for Covered Health Services, you (or the provider if they prefer) must send the bill to UHC for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UHC at the address on the back of your ID card.

If you receive Covered Health Services from Non-Network provider funds from your HRA will automatically be reimbursed to you, up to the amount available in your HRA. You will only be reimbursed from your HRA for expenses incurred while you are a Covered Person under the Plan.

When to Submit a Claim

There are some types of claims that will not be processed automatically for which you will need to submit a claim. When Auto-rollover feature does not apply you must submit a claim for reimbursement from your HRA including any other types of expenses other than Covered Health Services and any health expenses not submitted to UHC.

If you receive a bill for Covered Health Services from a provider, you must send the bill to UHC for processing.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Prescription Drug Benefit Claims

How Will You Be Reimbursed for Pharmacy Expenses

When you visit a pharmacy or order your medications through mail order through the Internet at www.myuhc.com, UHC will automatically process your pharmacy claim directly through your HRA when you present your ID card. The pharmacy and UHC have an established process of sharing account balances, deductible and out-of-pocket information in real time. Thus, there will be no out-of-pocket expense for you until you spend your entire HRA balance. Once you do spend down the balance in your HRA you will need to pay the pharmacy at the point of sale. You are responsible for paying expenses as described in this Summary Plan Document.

How to File Your Claim for Reimbursement from the HRA

To be reimbursed from your HRA simply submit a reimbursement form, called a Request for Withdrawal Form, for the HRA Eligible Expenses that have been incurred. A Request for Withdrawal Form is available from OptumBank or on the Internet at www.myuhc.com. For reimbursement from your HRA, you must include proof of the expenses incurred as indicated on the Request for Withdrawal Form. For HRA Eligible Expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from your medical plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors, and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical plans.

To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UHC HRA Claims submittal address:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506

IMPORTANT

YOU CAN VIEW EOB'S AND HEALTH STATEMENTS ONLINE VIA WWW.MYUHC.COM. MYUHC.COM INCLUDES MANY FEATURES SUCH AS THE OPTION TO:

- View your HRA summary page detailing contributions and amount left in your HRA;
- View your HRA Claims Summary including claim transaction details.

Health Statements

Each month that UHC processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UHC send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com.

Requesting Reimbursement from Your HRA

If you have allocated funds available in your HRA you may submit a claim for reimbursement for the HRA Eligible Expenses from your HRA. If you do submit a request for reimbursement for Network claims, the request must be received no later than 365 days following the end of the Plan year in which you are eligible under this Plan. All claim forms for Non-Network claims must be submitted within 12 months after the date of service. If you don't provide this information to UHC within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

You cannot be reimbursed for any expense paid under your medical plan, and any expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

IMPORTANT NOTE

THE DATE ON WHICH YOU INCURRED AN ELIGIBLE MEDICAL EXPENSE IS USED WHEN DEDUCTING AMOUNTS FROM YOUR HRA. THIS ALLOWS YOUR HRA TO ACT LIKE A SAVINGS ACCOUNT, AVAILABLE FOR YOUR USE WHEN YOUR CLAIM IS PAID.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UHC at the number on your ID card before requesting a formal appeal. If UHC cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card;
- The provider's name;
- The date of medical service or expense;
- The reason you disagree with the denial (including citations to specific provisions of the plan on which you are relying); and
- Any documentation or other written information to support your request.

If you wish to request a formal appeal of a denied claim for reimbursement, you should call the number provided by T-Mobile USA, Inc. to obtain the UHC address where the appeal should be sent. For Urgent Care claims that have been denied, you or your provider can call UHC at the toll-free number on your ID card to request an appeal.

Medical claims appeals should be sent to:

UnitedHealthcare Appeal
P.O. Box 30432
Salt Lake City, UT 84131-0432

Appeals for your HRA should be submitted to:

UHC — HRA Group Claims
P.O. Box 981178
El Paso, TX 7998-1178

Review of an Appeal

UHC will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination; and
- A health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UHC upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UHC within 60 days from receipt of the first level appeal determination.

NOTE: *Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions, and comments as part of the internal claims review process. UHC will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.*

For information on how your Benefits under this Plan coordinate with other medical plans and how coverage is affected if you become eligible for Medicare, refer to *Coordination of Benefits (COB)*.

Overpayment and Underpayment of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan. For further information on COB refer to *Coordination of Benefits (COB)*.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement, as defined in the following SPD Section — *Subrogation and Reimbursement*.

WHEN HRA COVERAGE ENDS

Your coverage under the Plan ends as described in this Summary Plan Document, Section — *Termination of Coverage*.

Continuation of Coverage — Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Reimbursement Account. See "Optional Continuation Coverage under your Health Care Spending Account (COBRA)."

COBRA continuation coverage will be offered with respect to your HRA. If your employment terminates for any reason the funds in your HRA will revert back to T-Mobile after your claim run-out period, unless you elect COBRA coverage as described in this Summary Plan Document, Continuation of Health Coverage (COBRA). If you elect COBRA coverage, HRA funds will remain available to assist you in paying your out-of-pocket costs under the medical plan while COBRA coverage is in effect. The HRA balances under COBRA are recalculated using the methods elected by T-Mobile USA, Inc. for mid-year enrollment and/or status changes; as described in Section — *Health Reimbursement Account* under heading *How the HRA Works* and look for “New Hires and Adjustments for Status Changes”.

HRA Glossary

Many of the terms used throughout this section may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how benefits are paid. This Section defines terms used throughout this section, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this Section have the meaning set forth in this Summary Plan Document.

HRA — Health Reimbursement Account or HRA. It is an Internal Revenue Code Section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA Eligible Expense — a health care expense that you incur on or after the date you are enrolled in the HRA Plan and include the following: (i) an eligible medical expense as defined in Section 213(d); (ii) that is an Eligible Expense as defined in this Summary Plan Document, including Prescription Drugs (iii) a medical expense not paid for under your active medical Plan as it represents your portion of responsibility for the cost of health care such as Annual Deductible, coinsurance (percentage of medical expense that you pay) and copayments; and (iv) a medical expense not reimbursable through any other plan covering health benefits, other insurance, or any other accident or health plan.

HRA Plan — The Health Reimbursement Account portion of the Health Reimbursement Account (HRA) Plan.

CLAIMS INFORMATION — HOW AND WHEN TO FILE A CLAIM

If You Receive Covered Health Services from a Network Provider

UHC, as the Claims Administrator pays Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact UHC. However, you are responsible for meeting the annual deductible, if applicable, and for paying Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits

When you receive Covered Health Services from a Non-Network provider as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from UHC. You must file the claim in a format that contains all of the information required, as described below.

You must submit a request for payment of benefits within one year after the date of service. **If a Non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission**. If you don’t provide this information to UHC within one year of the date of service, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If an Employee provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Employee. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a Non-Network provider without UHC's consent. When you assign your Benefits under the Plan to a Non-Network provider with UHC's consent, and the Non-Network provider submits a claim for payment, you and the Non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UHC has not consented to an assignment, UHC will send the reimbursement directly to you (the Participant) for you to reimburse the Non-Network provider upon receipt of their bill. However, UHC reserves the right, in its discretion, to pay the Non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UHC may consider whether you have requested that payment of your Benefits be made directly to the Non-Network provider. Under no circumstances will UHC pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a Non-Network provider shall not be deemed to constitute consent by UHC to an assignment or to waive the consent requirement. When UHC in its discretion directs payment to a Non-Network provider, you remain the sole beneficiary of the payment, and the Non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UHC may in its discretion send information concerning the Benefits to the Non-Network provider as well. If payment to a Non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to Refund of Overpayments in the Coordination of Benefits section.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UHC in its discretion determines to be adequate.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Participant's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

You should file the above information with the Claims Administrator at the address on your ID card.

HOW CLAIMS ARE PAID

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor,

or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- Is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- Is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- Shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments in Coordination of Benefits*.

Eligible Expenses due to a Non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from UHC within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UHC will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, UHC will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim and was submitted properly with all of the needed information, you will receive written notice of the claim decision from UHC within 15 days of the claim. If you filed a pre-service claim improperly, UHC will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UHC will notify you of the information needed within 15 days after the claim was received and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, UHC will notify you of the determination within 15 days after the information is received. If you don't

provide the information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after UHC receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent care claim improperly, UHC will notify you of the improper filing and how to correct it within 24 hours after the urgent claims was received. If additional information is needed to process the claim, UHC will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

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

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UHC will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

INCENTIVES TO PROVIDERS

Network providers may be provided financial incentives by the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments — certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You

may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in the UHC medical benefits table.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

QUESTIONS AND APPEALS

Review and Determine Benefits in Accordance with UHC Reimbursement Policies

The Claims Administrator adjudicates claims consistent with industry standards. The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse, and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings. The Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of the Claims Administrator's reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may apply a reimbursement methodology established by OptumInsight and/or a third-party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to the Claims Administrator's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs, administrative programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but T-Mobile recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions.

What to Do First

If your question or concern is about a benefit determination, you may informally contact UHC before requesting a formal appeal. If UHC cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "How to File a Claim" you may appeal it as described below, without first informally contacting UHC. If you first informally contact UHC and later wish to request a formal appeal in writing, you should contact UHC and request an appeal.

If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact UHC immediately.

UHC Member Services: 1-877-259-1527

Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and the identification number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you disagree with the denial (including citations to specific provisions of the plan on which you are relying); and.
- Any documentation or other written information to support your request.

The address to send this communication is:

UHC — Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. UHC may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEAL DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of a decision on your appeal as follows:

For appeals of **pre-service claims** (as defined in How to File a Claim), the first level appeal will be conducted, and you will be notified by UHC of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted, and you will be notified by UHC of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of **post-service claims** (as defined in How to File a Claim), the first level appeal will be conducted, and you will be notified by UHC of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level

appeal will be conducted, and you will be notified by UHC of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "**Urgent Claim Appeals That Require Immediate Action**" below.

If you are not satisfied with the first level appeal decision of UHC, you have the right to request a second level appeal from UHC as the Claims Administrator. Your second level appeal request must be submitted to UHC within 60 days from receipt of first level appeal decision.

For pre-service and post-service claim appeals, we have delegated to UHC the exclusive right to interpret and administer the provision of the Plan. UHC's decisions are conclusive and binding. Please note that UHC's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call UHC as soon as possible. UHC will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The table below describes the timeframes which you and UHC are required to follow:

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UHC must notify you within:	**24 hours**
You must then provide completed request for Benefits to UHC within:	**48 hours** after receiving notice of additional information required
UHC must notify you of the benefit determination within:	**72 hours**
If UHC denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UHC must notify you of the appeal decision within:	**72 hours** after receiving the appeal

* *You do not need to submit Urgent Care appeals in writing. You should call UHC as soon as possible to appeal an Urgent Care request for Benefits.*

For urgent claim appeals, we have delegated to UHC the exclusive right to interpret and administer the provisions of the Plan. UHC's decisions are conclusive and binding.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UHC, or if UHC fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UHC's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or

- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UHC's decision.

An external review request should include all of the following:

- A specific request for an external review;
- The Covered Person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UHC has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UHC of the request;
- A referral of the request by UHC to the IRO; and
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UHC will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that UHC may process the request.

After UHC completes the preliminary review, UHC will issue a notification in writing to you. If the request is eligible for external review, UHC will assign an IRO to conduct such review. UHC will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO's request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UHC will provide to the assigned IRO the documents and information considered in making UHC's determination. The documents include:

- All relevant medical records;
- All other documents relied upon by UHC; and
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UHC will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UHC. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives

the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UHC, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UHC's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UHC's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UHC will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; and
- Has provided all the information and forms required so that UHC may process the request.

After UHC completes the review, UHC will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UHC will assign an IRO in the same manner UHC utilizes to assign standard external reviews to IROs. UHC will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UHC. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UHC.

You may contact UHC at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against T-Mobile USA, Inc. or UHC to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against T-Mobile USA, Inc. or UHC, you must do so within three years of the date you are notified of your final decision on your appeal or you lose any rights to bring such an action against T-Mobile USA, Inc. or UHC.

You cannot bring any legal action against T-Mobile USA, Inc. or UHC for any other reason unless you first complete all the steps in the internal appeal process described in this section. After completing that process, if you want to bring a legal action against T-Mobile USA, Inc. or UHC, you must do so within three years of the date you are notified of your final decision on your internal appeal or you lose any rights to bring such an action against T-Mobile USA, Inc. or UHC.

MEDICAL PLAN GLOSSARY

(These definitions apply when the following terms are used and are not intended to describe Benefits.)

Air Ambulance

Medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

Alternate Facility

A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services;
- Emergency Health Services; or
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Ambulatory Surgical Center

A specialized facility that is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed Doctor of Medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area;
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
  - It provides at least one operating room and at least one post-anesthesia recovery room;
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services;
  - It has trained personnel and necessary equipment to handle emergency situations;
  - It has immediate access to a blood bank or blood supplies;
  - It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or X-rays, an operative report, and a discharge summary.

An Ambulatory Surgical Center that is part of a Hospital, as defined herein, will be considered an Ambulatory Surgical Center for the purposes of this Plan.

Ancillary Services

Items and services provided by Non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a Non-Network Physician when no other Network Physician is available.

Autism Spectrum Disorder

A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law;
  - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity;
  - It has ability to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
  - It is operated under the full-time supervision of a licensed Doctor of Medicine (M.D.), doctor of osteopathy (D.O.) or registered graduate nurse (R.N.);
  - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications;
  - It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary; and
  - It is expected to discharge or transfer patients within 24 hours following delivery.

A Birth Center that is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of this Plan.

BMI

A measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone. Also referred to as Body Mass Index.

Coinsurance

The charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services.

Congenital Anomaly

A physical development defect that is present at birth and is identified within the first twelve months of birth.

Copayment (or Copay)

The charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in the UnitedHealthcare section of this SPD

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable

Comprehensive Outpatient Rehabilitation Facility

A facility which is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured or sick persons and which fully meets one of the following two tests:

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility.
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
    - Services of Physicians who are available at the facility on a full- or part-time basis;
    - Physical therapy; and
    - Social or psychological services.
- It has policies established by a group of professional personnel (associated with the facility) including one or more Physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full or part-time Physician;
- It has a requirement that every patient must be under the care of a Physician; and
- It is established and operated in accordance with the applicable licensing and other laws.

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function and not otherwise covered as gender dysphoria benefits under the Plan, as determined by UHC on the Plan's behalf.

Covered Health Services

Those health services, including services or supplies, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services condition, disease, or their symptoms.
- Included in *Plan Highlights* and *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility*.
- Not identified in Section 8, *Exclusions and Limitations*.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on www.myuhc.com or by calling the number on your ID card. This information is available to Physicians and other health care professionals on www.UHCprovider.com.

Covered Family Members or Covered Person

The Employee and the Employee's Spouse, Domestic Partner, and/or Dependent Children who are covered under this Plan. References to “you” and “your” throughout this SPD are references to a Covered Person.

Custodial Care

Services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring, and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel to be delivered safely and effectively.

Deductible

The amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses below.

Designated Dispensing Entity — a pharmacy, provider, or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits

For Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Medical Benefits Summary Table, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider

A provider and/or facility that:

- Has entered into an agreement with UHC, or with an organization contracting on UHC's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UHC has identified through UHC's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UHC at www.myuhc.com or calling UHC Member Services at **1-877-259-1527**.

Eligible Expenses

For Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UHC as stated below and as detailed in *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UHC’s reimbursement policy guidelines. UHC develops the reimbursement policy guidelines, in UHC’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);

- As reported by generally recognized professionals or publications;
- As used for Medicare; or
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UHC accepts.

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Services

With respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Employee

Regular Full-Time Employees who are consistently scheduled to work 30 or more hours per week; and **Regular Part-Time Employees** who are consistently scheduled to work 20 or more hours per week.

Emergency Health Services

With respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a Non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
  - The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

- The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
- The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
- Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied. Benefits are available for services to treat a condition that does not meet the definition of an Emergency.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for the proposed use in any of the following:
- *AHFS D*rug Information (AHFS DI) under therapeutic uses section;
- Elsevier Gold Standard's Clinical Pharmacology under the indications section;
- DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
- National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial [[8]as described under *Additional Coverage Details* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Family and Medical Leave Act of 1993 (FMLA)

See the detailed description of the provisions of FMLA in the Employee manual.

Gender Affirming Care

A condition characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.*

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least three months' duration, as manifested by at least two of the following:

    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics);
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics);
    - A strong desire for the primary and/or secondary sex characteristics of another gender;
    - A strong desire to be of another gender (including a non-binary gender);
    - A strong desire to be treated as a gender different from one's assigned gender (including a non-binary gender); and
    - A strong conviction that one has the typical feelings and reactions of another gender (including a non-binary gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender and assigned gender, of at least three months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of another gender or an insistence that one is another gender (including a non-binary gender different from one's assigned gender);
    - In those assigned male at birth, a strong preference for wearing clothing considered to be typically feminine; or in those assigned female at birth, a strong preference for wearing clothing considered to be masculine and a strong resistance to the wearing of clothing considered to be typically feminine;
    - A strong preference for a gender role in make-believe play or fantasy play that is different than the child's assigned gender;
    - A strong preference for the toys, games or activities stereotypically used or engaged in by a gender different than the child's assigned gender;
    - A strong preference for playmates of another gender than the child's assigned gender;
    - In those assigned male at birth, a strong rejection of stereotypically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in those assigned female at birth, a strong rejection of stereotypically feminine toys, games, and activities;
    - A strong dislike of ones' sexual anatomy; and
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced (rather than assigned) gender.
- The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Genetic Counseling

Counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks, and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

- Certified genetic counselors, medical geneticists, and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing

Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier

A Gestational Carrier is an individual who becomes pregnant by having a fertilized egg (embryo) implanted in their uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Home Health Agency

A program or organization authorized by law to provide health care services in the home.

Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice;
- It is licensed in accordance with any applicable state laws; or
- It meets the following criteria:
  - It provides 24 hour-a-day, 7 day-a-week service;
  - It is under the direct supervision of a duly qualified Physician;
  - It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
  - The main purpose of the agency is to provide Hospice services;
  - It has a full-time administrator;
  - It maintains written records of services given to the patient; and
  - It maintains malpractice insurance coverage.

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of this Plan.

Hospital

An institution, operated as required by law, which is both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of Physicians; and
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care, or care of the aged and is not a nursing home, convalescent home, or similar institution.

Iatrogenic Infertility

An impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Independent Freestanding Emergency Department

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Infertility

A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

Injury

Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility

A Hospital (or a special unit of a Hospital that is designed as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Intensive Outpatient Programs

A structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Medically Necessary

Health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice;
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms;
- Not mainly for your convenience or that of your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease, or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UHC reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UHC's sole discretion.

UHC develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UHC and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Disorder Treatment / Mental Health Services

Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Delegate

The organization or individual designated by T-Mobile USA, Inc., who provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services.

Mental Illness

Those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS)

A program administered by UHC or its affiliates made available to you by T-Mobile USA, Inc. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network Provider

A provider that has a participation agreement in effect with UHC or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

New Pharmaceutical Product

A Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

No-Fault Automobile Insurance Law

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Hospital

A Hospital (as defined) that does not participate in the network.

Non-Network Provider

A provider that does not participate in the network.

Nurse-Midwife

A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse; and
- A person who has completed a program approved by the state for the preparation of Nurse-Midwives.

Nurse-Practitioner

A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse; and
- A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

Other Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Partial Hospitalization/Day Treatment/High Intensity Outpatient

A structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s)

U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician

A legally qualified:

- Doctor of Medicine (M.D.);
- Doctor of Chiropody (D.P.M.; D.S.C.);
- Doctor of Chiropractic (D.C.);
- Doctor of Dental Surgery (D.D.S.);
- Doctor of Medical Dentistry (D.M.D.);
- Doctor of Osteopathy (D.O.);
- Doctor of Podiatry (D.P.M.); or
- Doctor of Naturopathic Medicine (N.D.) — Limited benefits; see heading “Naturopath Physician” under Covered Services and Supplies.

NOTE: *Any podiatrist, dentist, psychologist, chiropractor, or other provider who acts within the scope of their license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.*

Plan

T Mobile USA, Inc. Employee Benefit Plan, as described herein.

Plan Year

A period of time beginning January 1 and ending December 31.

Pregnancy

Pregnancy includes all of the following:

- Prenatal care;
- Postnatal care;
- Childbirth; and
- Any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT)

A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-A — for aneuploidy (formerly PGS)
- PGT-M — for monogenic disorder (formerly single-gene PGD).
- PGT-SR — for structural rearrangements (formerly chromosomal PGD).

Preventive Care Medications

The medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance or Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UHC at the toll-free telephone number on your ID card.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist; or
- A Member or Fellow of the American Psychological Association if there is no government licensure or certification required.

Reasonable and Customary Charge

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by UHC in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by UHC by comparing the actual charge for the service or supply with the prevailing charges made for it. UHC determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Recognized Amount

The amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by Non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by Non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Health Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on either:

- An All-Payer Model Agreement if adopted,
- State law, or
- The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a Non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

NOTE: *Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.*

Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Remote Physiologic Monitoring — the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment — a program of Mental Health Services or Substance-Related and Addictive Disorders Services that meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.

- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

Residential Treatment Facility — a Hospital or facility, licensed and operated as required by law, that provides Residential Treatment.

Review or Review Process

A review and determination that the services and supplies are Covered Health Services.

Room and Board

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Secretary

As that term is applied in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*.

Semi-Private Room

A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness

Physical illness, disease, or Pregnancy. The term Sickness as used in this SPD includes mental illness or substance-related and addictive disorders.

Skilled Nursing Facility

A Hospital or nursing facility that is licensed and operated as required by law.

Specialist

A Physician who has a majority of their practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialized Facility

A facility which is a Non-Network facility, and which holds a license that is not the same type held by any Network Provider.

Specialized Provider

A provider who is a Non-Network Provider but who also holds a health care professional license that is not the same type held by any Network Provider in the service area in which the services are rendered.

Specialty Pharmaceutical Product

Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spinal Treatment

Detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance-Related and Addictive Disorders Services

Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual* published by the *American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate

An individual who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child.

Telehealth / Telemedicine

Live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI)

Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living

Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery. **Please Note:** These living arrangements are also known as supportive housing (including recovery residences).

Treatment Center

A facility that provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a Physician and UHC;
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient; and
- It provides at least the following basic services:

- Room and Board (if this Plan provides inpatient benefits at a Treatment Center);
- Evaluation and diagnosis;
- Counseling; and
- Referral and orientation to specialized community resources.

A Treatment Center that qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

UnitedHealth Premium Program

A program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services

Health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical or behavior health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-designed system reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case control studies cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

NOTE: *If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.*

Urgent Care

Care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office, or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center

An entity that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Surest (Copay Only) Medical Plan

QUICK REFERENCE

This section is a quick reference guide.

Website: Access to what is covered, how much it costs, and where you can get care.	**Once enrolled:** Benefits.Surest.com
Mobile App: Access — from your smartphone — to what is covered, how much it costs, and where you can get care.	**Once enrolled:** Surest mobile app
Phone Numbers: Who to contact to help answer any questions.	**Surest Copay Only Plan Questions:** Surest Member Services Team 1-844 530 0323 Monday – Friday 4:00 am to 7:00 pm Pacific
Name of the Plan:	T-Mobile USA, Inc., Employee Benefit Plan
Plan Administrator: Who is ultimately responsible for administering the Surest Copay Only Plan.	T-Mobile USA, Inc.
Claims Administrator: Who processes Claims, administers appeals, and runs the Surest Member Services team, Surest mobile app, and Benefits.Surest.com website.	Surest
Medical Claims Mailing Address: Where to mail medical Claims and written inquiries.	Surest P.O. Box 211758 Eagan, MN 55121

WHAT ARE MY BENEFITS?

Claims for Benefits under the Surest Copay Only Plan are payable only for Covered Health Services that are Medically Necessary.

The total cost of Covered Health Services is shared between you and the Plan Sponsor. Your share consists of paycheck deductions and copayments. The Surest Copay Only Plan does not have a deductible or coinsurance. Your Surest Copay Only Plan does have an out-of-pocket maximum which is the maximum amount of copayments you will pay each Plan Year for Covered Health Services

Surest assigns prices to Covered Health Services. These prices are also referred to as copayments. Your copayments for Covered Health Services are listed in Covered Health Services and on the Surest mobile app and Benefits.Surest.com website.

The Surest Copay Only Plan provides Benefits for the remainder of the amount billed by your in-network Provider for Covered Health Services after any discounts are applied.

Discounts are negotiated with in-network Providers. If you use an in-network Provider, you may be responsible for lower copayments and the Provider may not charge you any additional fees. If you use an out-of-network Provider, there are limited Benefits available as described in the Covered Health Services table below (e.g., ambulance, Emergency room, and certain diagnostic lab, ultrasounds, x-rays). You will be responsible for (in addition to your higher out-of-network copayments) all amounts that exceed the discounts negotiated through the Shared Savings Program, over the Usual and Customary amount, or up to billed charges. Out-of-network Providers may be permitted to bill you for the difference between what the Plan agreed to pay and the full amount charged for a Covered Health Service. This is called “balance billing.”

Once your total copayments reach your applicable out-of-pocket maximum, the Surest Copay Only Plan provides Benefits at 100% of Eligible Charges for the remainder of the Plan Year, except for amounts you pay for out-of-network Covered Health Services in excess of the usual and customary amount, when applicable. Amounts in excess of usual and customary charges are not counted towards your out-of-pocket maximums.

In-Network Benefits

As a Participant in the Surest Copay Only Plan, you may choose any eligible Provider of health services each time you need to receive a Covered Health Service. The choices you make may affect the amount you pay, as well as the level of Benefits you receive. You will receive the highest level of Benefits from the Surest Copay Only Plan (and in most instances, your out-of-pocket expenses will be far less) when you receive care from in-network Providers. The Surest Plan’s credentialing process confirms public information about the Providers’ licenses and other credentials but does not assure the quality of their services. The Providers are independent practitioners and entities that are solely responsible for the care they deliver. The Surest Copay Only Plan features a large network of in-network Providers which can be found in the Surest mobile app or Benefits.Surest.com website or you can call Surest Member Services for assistance.

These in-network Providers will:

1) File Claims for Benefits for you.

2) Accept payment based on the discounted rate previously negotiated.

In-network Providers are responsible for obtaining Prior Authorization, Pre-Admission Notification, pre-admission certification for planned inpatient admissions, and/or Emergency admission notification requirements for you. Therefore, it is important that you confirm the Provider's status before you receive services as a Provider’s network status may change. For current in-network Provider information, refer to the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance.

If you receive health care services from an out-of-network Provider and were informed incorrectly by the Claims Administrator prior to receipt of the Covered Health Service that the Provider was an in-network Provider, either through the Surest Plan database, provider directory, or in the Claims Administrator’s response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for the same copayment that would apply if the Covered Health Service had been provided from an in-network Provider.

You will need to show your member identification “ID” card each time you request health care services from an in-network Provider. Your member ID card can be found on the Surest mobile app; you will also receive an actual member ID card in the

mail. If you do not show your member ID card, in-network Providers have no way of knowing that you are enrolled under the Surest Plan. As a result, they may bill you for the entire cost of the services you receive.

We have agreements in place that govern the relationship between us, our Groups and in-network Providers, some of which are affiliated Providers. In-network Providers enter into agreements with us to provide Covered Health Services to Participants. Do not assume that an in-network Provider's agreement includes all Covered Health Services. Some in-network Providers contract with Surest to provide only certain Covered Health Services, but not all Covered Health Services. Some in-network Providers choose to be an in-network Provider for only some of our Covered Health Services. Refer to the Surest mobile app or Benefits.Surest.com website or call Surest Member Services for assistance.

For in-network benefits for Covered Health Services provided by an in-network Provider, except for your copayment obligations, you are not responsible for any difference between the Eligible Charge and the amount the Provider bills. Eligible Charges are based on the following:

- When Covered Health Services are received from an in-network Provider, Eligible Charges are our contracted fee(s) with that Provider.
- When Covered Health Services are received from an out-of-network Provider as arranged by the Claims Administrator, Eligible Charges are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable copayment. Surest will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

The Surest Copay Only Plan provides limited Benefits for certain medical Claims incurred with an out-of-network Provider (e.g., ambulance, Emergency Room, Observation Stay). As a result, if you choose to seek health services out of network, except as described below, services will not be covered.

For Covered Health Services that are ***Ancillary Services received at certain in-network facilities on a non-Emergency basis from out-of-network Providers***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your copayment which is based on the Recognized Amount as defined in the Glossary.

- For Covered Health Services that are ***air ambulance services provided by an out-of-network Provider***, you are not responsible (and the out-of-network Provider may not bill you) for amounts in excess of your applicable copayment which is based on the rates that would apply if the service was provided by an in-network Provider.

Eligible Charges are determined in accordance with our reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As indicated in the most recent editions of the Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) Codes.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts. In-network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage of the published rates allowed by CMS for Medicare for the same or similar service within the geographic market.

When Covered Health Services are received from an out-of-network Provider as described below, Eligible Charges are determined, as follows:

- **For Emergency health care services provided by an out-of-network Provider**, the Eligible Charge is based on one of the following:
  - The reimbursement rate as determined by applicable federal or state law or by an applicable state *All Payer Model Agreement*.

- The initial payment made by us or the amount subsequently agreed to by the out-of-network Provider and us.
- The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your applicable copayment which is based on the Recognized Amount as defined in the Glossary.

- **For air ambulance transportation provided by an out-of-network Provider**, the Eligible Charge is based on one of the following:
  - The reimbursement rate as determined by applicable federal or state law or by an applicable state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator or the amount subsequently agreed to by the out-of-network Provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-network Provider may not bill you, for amounts in excess of your copayment which is based on the rates that would apply if the service was provided by an in-network Provider which is based on the Recognized Amount as defined in the Glossary.

- **For ground ambulance transportation provided by an out-of-network Provider**, the Eligible Charge, which includes mileage, is a rate agreed upon by the out-of-network Provider and the Claims Administrator, or, unless a different amount is required by applicable law, determined based on the median amount negotiated with in-network Providers for the same or similar service.

IMPORTANT NOTICE: Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Recognized Amount as defined in the Glossary.

Except as described above, out-of-network Benefits apply to certain Covered Health Services that are provided by an out-of-network Provider, or Covered Health Services that are provided at an out-of-network facility (e.g., ambulance, Emergency room, and Observation Stay).

If the Claims Administrator confirms that care is not available from an in-network Provider, the Claims Administrator will work with you to coordinate care through an out-of-network Provider as outlined in the written policy established by the Claims Administrator. Covered Health Services rendered by an out-of-network Provider will be processed at the in-network Benefit level when there are no available in-network Providers. Requests for this Benefit should be made by calling Surest Member Services at the number on your member ID card **before** you obtain such services.

Out-of-network Providers are not required to file Claims with Surest. Any submitted Claim for out-of-network providers will be denied, except as specifically described within this SPD.

Copayments

A copayment is the amount you pay each time you receive certain Covered Health Services. The table below describes how your coverage works and includes copayments applicable to the Covered Health Services you choose. Some copayments are listed as a range. Surest assigns Provider copayments within the ranges based on the Surest analysis of treatment outcomes and cost information that identifies Physicians, clinics, and hospitals that provide cost-efficient care.

For current Provider-specific copayment information, Participants should check the Surest mobile app or Benefits.Surest.com or call Surest Member Services prior to utilizing any services covered under the Surest Copay Only Plan.

The full range of copayments displayed may not be available in all geographical areas or for all services. You can find Provider-specific copayment amounts by utilizing the 'Search tool' on the Surest mobile app or Benefits.Surest.com or call Surest Member Services.

You may also be eligible for reduced copayments for certain Benefits and for specific focused programs if you use in-network Providers that Surest has designated as preferred, high-value Providers.

The following chart shows the deductibles and out-of-pocket maximums for the Surest Copay Only Plan.

Benefit Features

The Surest Plan	In-Network	Out-of-Network
Deductible	$0	$0
Out-of-Pocket Maximum per Plan Year	**In-Network**	**Out-of-Network**
Individual	$6,500	Not Applicable
Family	$13,000	Not Applicable

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- If you enroll in individual coverage, once you reach the out-of-pocket maximum for a plan year, benefits are payable at 100% of the eligible charge during the rest of that plan year.
- If you have other family members enrolled (Family coverage) in the Surest Copay Only Plan, they have to meet their own individual out-of-pocket maximum until the overall family out-of-pocket maximum has been met. Once any enrolled family member has reached the individual out-of-pocket maximum, the Surest Copay Only Plan will pay 100% of that individual's Eligible Expenses for Covered Health Services for the rest of the Plan Year, even if the family out-of-pocket maximum has not yet been met.
- You must pay any amounts greater than the out-of-pocket maximum if any Benefit, day, or visit maximums are exceeded, and for health care services that are not Covered Health Services. Expenses you pay for any amount in excess of the usual and customary amount will not apply towards satisfaction of the out-of-pocket maximum.

Covered Health Services

Ambulance Services	In-Network	Out-of-Network
Ambulance Services	$400 copayment / transport	$400 copayment / transport

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Ambulance Services copayment applies to the in-network out-of-pocket maximum.
- Ground or air ambulance, as the Claims Administrator determines appropriate. Air ambulance is medical transport by helicopter or airplane.
- Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest hospital that offers Emergency health services.
- Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy.
- Non-Emergency ambulance transportation provided by a licensed ambulance service (either ground or air ambulance) between facilities only when the transport meets one of the following:
  - From an out-of-network hospital to the closest in-network hospital when Covered Health Services are required.
  - To the closest in-network Hospital that provides the required Covered Health Services that were not available at the original Hospital.
  - From a short-term acute care facility to the closest in-network long-term acute care facility (LTAC), in-network Inpatient Rehabilitation Facility, or other in-Network sub-acute facility where the required Covered Health Services can be delivered.
  - For purposes of this Benefit, the following terms have the following meanings:

  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.
- Ambulance services for non-Emergency: The Surest Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as Surest determines appropriate) between facilities when the transport is:
  - From an out-of-network hospital to an in-network hospital.
  - To a hospital that provides the required care that was not available at the original hospital.
  - To a more cost-effective acute care facility.
  - From an acute care facility to a sub-acute care setting.
- Non-Emergency air ambulance services require Prior Authorization and Medical Necessity review.

Behavioral Health: Mental Health and Substance Use Disorder Services	In-Network	Out-of-Network
Mental Health Office Visit (including Telehealth Visit)	$25 copayment / visit	Not Covered
Applied Behavioral Analysis (ABA) Therapy	$25 copayment / visit	Not Covered
Mental Health Biofeedback	$25 copayment / visit	Not Covered
Mental Health Habilitative, Cognitive, Occupational Therapy	$15 copayment / visit	Not Covered
Mental Health Physical Therapy	$15 copayment / visit	Not Covered
Mental Health Speech Therapy	$15 copayment / visit	Not Covered
Electroconvulsive Therapy (ECT)	$170 copayment / visit	Not Covered
Intensive Outpatient Treatment Program (IOP)	$90 copayment / visit	Not Covered
Outpatient Alcohol and Drug Treatment Program	$170 copayment / visit	Not Covered
Partial Hospitalization (PHP)/Day Treatment	$170 copayment / day	Not Covered
Substance Use Disorder Medication Therapy	$20 copayment / visit	Not Covered
Transcranial Magnetic Stimulation (TMS) Therapy	$150 copayment / visit	Not Covered
Residential Treatment Facility Care	$3,500 copayment / stay	Not Covered
Outpatient Mental Health	$70 copayment / visit	Not Covered
Inpatient Hospital	$3,500 copayment / stay	Not Covered
Virtual Care	See Virtual Care section for details	Not Applicable

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Benefits include:
  - Diagnostic evaluations, assessment, and treatment planning.
  - Other treatments and/or procedures.
- Medication management and other associated treatments.
  - Methadone Maintenance.
  - Individual, family, and group therapy.
  - Provider-based case management services.
  - Crisis intervention.
  - Intensive Outpatient Treatment program (IOP) (a structured outpatient mental health or substance use treatment program at a freestanding or hospital-based facility and provides services for at least three hours per day, two or more days per week).
  - Residential treatment.
  - Partial hospitalization (PHP)/Day treatment (a structured ambulatory program that may be freestanding or hospital-based and provides services for at least 20 hours per week).
  - Other Outpatient treatment.
- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.

- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Nutritional Counseling for mental health or substance use disorder does not have visit limits.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Inpatient residential and partial hospitalization services may require Prior Authorization and Medical Necessity review.
- Refer to the Gender Affirming Care section for additional coverage information.

The Surest Copay Only Plan provides Benefits for behavioral services for Autism Spectrum Disorder, including Intensive Behavioral Therapies (IBT) such as Applied Behavior Analysis (ABA) that are the following:

  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, property, or impairment in daily functioning.
  - Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.

- Intensive Behavioral Therapy (IBT) is outpatient behavioral care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age-appropriate skills in Participants with Autism Spectrum Disorder.
- These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.
- Visit limits do not apply to therapies provided for a mental health condition, such as autism disorders.
- Applied Behavioral Analysis for Autism Spectrum Disorder services may require Prior Authorization and Medical Necessity review.

Colonoscopy — Non-Screening	In-Network	Out-of-Network
Colonoscopy — Non-Screening	$0 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- Coverage is available for a non-screening colonoscopy received on an outpatient basis at a hospital, alternate facility, or in a Physician’s office.
- A non-screening colonoscopy is a procedure performed to diagnose disease symptoms.
- Services for preventive screenings are provided under the Preventive Care Services section.
- A preventive colonoscopy screening can change to a non-screening colonoscopy (with applicable copay) if the Provider finds and removes polyps or does a biopsy.

Complex Imaging	In-Network	Out-of-Network
MRI (Magnetic Resonance Imaging)	$200 to $1,050 copayment / visit	Not Covered
CT (Computed Tomography)	$150 to $950 copayment / visit	Not Covered
Nuclear Imaging	$200 to $1,050 copayment / visit	Not Covered
PET Scan	$200 to $2,000 copayment/visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- If imaging occurs on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, one copayment applies.
- If imaging occurs using different types of imaging machines (e.g., MRI and a CT), on the same date of service, more than one copayment applies.
- If your Physician suggests a low-dose CT Scan (LDCT) for lung cancer screening, refer to Preventive Care Services, in this section, for coverage notes.

Dental and Oral Services	In-Network	Out-of-Network
Orthognathic (Jaw) Surgery	$3,250 copayment / visit	Not Covered
Temporomandibular Joint (TMJ) Dysfunction Surgery	$700 copayment / visit	Not Covered
Accidental and Medical Dental — All Other Services:		
Office Visit	$25 to $130 copayment / visit	Not Covered
Outpatient Hospital Visit	$200 to $1,000 copayment / visit	Not Covered
Inpatient Hospital	$3,500 copayment / stay	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Dental Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- The Surest Copay Only Plan provides Benefits for dental services to treat and restore damage done to a sound, natural tooth as a result of an accidental injury. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss. Treatment and repair for services required due to an accidental injury must be started within six months and completed within twelve months of the date of the injury.

- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.
- The Surest Copay Only Plan also covers dental services, limited to dental services required for treatment of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.
- Eligible Charges for hospitalizations are those incurred by a Participant who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
- Accidental Dental Services may require Prior Authorization and Medical Necessity review.
- The Surest Copay Only Plan provides Benefits for services for orthognathic surgery and the evaluation and treatment of TMJ and associated muscles.
- Includes orthodontic services and supplies, and surgical and non-surgical options for the treatment of TMJ. Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatments have failed.
- Returning home from a visit with durable medical equipment, such an oral appliance, may result in an additional copayment.
- Orthognathic surgery and select services for TMJ Disorder may require Prior Authorization and Medical Necessity review.

Dialysis Services	In-Network	Out-of-Network
Dialysis	$75 to $450 copayment / visit	Not Covered
Home Dialysis	$90 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- The Surest Copay Only Plan provides Benefits for therapeutic treatments received in an office, home, outpatient hospital, or alternate facility.
- Benefit includes services and supplies for renal dialysis, including both hemodialysis and peritoneal dialysis.
- Benefit also includes training of the patient.
- Dialysis Services may require Prior Authorization and Medical Necessity review.

Durable Medical Equipment (DME) and Supplies	In-Network	Out-of-Network
Purchase:		
Tier 1 to Tier 12	$0 – $1,000 copayment	Not Covered
Rental:		
Tier 1 to Tier 12	$0 – $100 copayment / month	Not Covered

NOTES:

- Durable Medical Equipment (DME) and supplies are tiered based on average cost and allowed amount. Supplies such as tubing, syringes, and catheters are assigned to a lower tier and will result in a lower copayment. Equipment such as pumps and wheelchairs are assigned to a higher tier and will result in a higher copayment.
- Each piece of durable medical equipment and supplies are assigned to a tier, which corresponds to a copayment. A breakdown of the tiers and corresponding copayments can be found on Surest mobile app or Benefits.Surest.com.
- Returning home from an appointment with a health care Provider or from the hospital with durable medical equipment, such as crutches, may result in an additional copayment. Copayments will be dependent on the tier the item falls into.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula, nursing visit and administration).

The Surest Copay Only Plan provides the following Benefits for durable medical equipment, prosthetics, orthotics, and supplies (subject to any limitations noted below):

- Refer to the Surest mobile app for additional coverage and copayment information.
- This durable medical equipment and supplies list is subject to periodic review and modification (generally quarterly, but no more than six times per Plan Year).
- You may also view which tier a particular DME item has been assigned to by using the Surest mobile app or Benefits.Surest.com or calling Surest Member Services for assistance.
- Coverage includes rental or purchase of DME if Medically Necessary, ordered or provided by a Physician for outpatient use primarily in a home setting, serves a medical purpose for the treatment of an illness or injury, and is not of use to a Participant in the absence of a disease or disability. If you need certain durable medical equipment for an extended period of time, there may be an option to rent. Length of rental may vary by DME item. The purchase copayment based on tier may be split over a period of time, at which point the DME may be considered "purchased" or coverage may end. Note that some equipment such as oxygen equipment will be set to rental for the duration of time the equipment is needed. Surest generally follows Centers for Medicare and Medicaid Services (CMS) guidelines on rental vs purchase. Refer to Surest mobile app or Benefits.Surest.com for additional information.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Cranial orthoses such as head shaping helmets and head reconstruction are a set of orthotic devices and services to reshape the head. They may be medically indicated for plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- Scalp/cranial hair prostheses (wigs) regardless of the reason for hair loss is a Covered Health Service where medically necessary.
- Hearing aids are limited to one per ear every 36 months. This limit only applies to prescription hearing aids and not over-the-counter hearing aids.
- Communication aids or devices; equipment to create, replace, or augment communication abilities, including but not limited to communication board or computer or electronic-assisted communication, speech processors, and receivers. Speech generating device, digitized speech, and using pre-recorded messages are eligible.
- Purchase of one standard breast pump, either manual or electric, per pregnancy. Participant may have to pay a surcharge to the Provider if they purchase enhanced models.

- Enteral Nutrition and low protein modified food products administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. The formula or product must be administered under the direction of a Physician or registered dietitian. (Example conditions include, but are not limited to, metabolic disease such as phenylketonuria (PKU) and maple syrup urine disease severe food allergies, and impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.)
- Shoes as prescribed by a Provider for a Participant. Limited to one pair per Plan Year.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Select Durable Medical Equipment (DME) may require Prior Authorization and Medical Necessity review.

Emergency Room Services	In-Network	Out-of-Network
Emergency Room Visit	$600 copayment / visit	$600 copayment / visit
Observation Stay	$600 copayment / stay	$600 copayment / stay

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Out-of-network Emergency Room Visit copayment applies to the in-network out-of-pocket maximum.
- Out-of-network Observation Stay copayment applies to the in-network out-of-pocket maximum.
- Copayment applies to Emergency room facility, professional expenses, and includes related expenses.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Emergency Room visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an Emergency Room visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- If you are admitted as an inpatient directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for Inpatient Hospital Services copayment.
- If the Emergency Room facility is unable to treat you, you may be referred to another Emergency Room facility or other Provider, you will be responsible for both Emergency Room copayments.
- If you are admitted to observation directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for the Observation Stay copayment.
- Refer to Hospital Services section for additional coverage notes.

Fertility Treatments — Designated Provider: Progyny	In-Network	Out-of-Network
Three (3) Smart Cycles per family (employee and spouse)	Up to $2,000 copayment per Smart Cycle limited to 3 Smart Cycles per lifetime	Not Covered
Two (2) Initial Consultations		Not Covered
Progyny Rx — fertility medications		Not Covered
Fertility preservation — Egg and sperm freezing coverage		Not Covered
Tissue storage (specific treatment)		Not Covered

Fertility treatments are administered through Progyny. Please call (833) 281-0076 to activate benefits.

Progyny administers T-Mobile's fertility benefits and offers comprehensive coverage to assist any member wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care. If you have any questions about your fertility benefit, please call your dedicated Progyny Patient Care Advocate, or you can call Progyny customer service at (833) 281-0076.

Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to):

- Artificial Insemination (IUI), Cryopreservation of oocytes and sperm
- FDA Bloodwork and Testing
- Fresh IVF Cycle
- Frozen Embryo Transfer (FET)
- Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer)
- IVF Freeze-All
- Patient Care Advocate (PCA) Concierge Support
- Pre-authorized fertility medications (via Progyny Rx)
- PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability
- PGT-M (PGD, or Pre-implantation Genetic Diagnosis)
- Pregnancy Gap Coverage (pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider)
- Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities), and the purchase of donor tissue (eggs and sperm)

Progyny's benefit has the following standard exclusions:

- Home ovulation prediction kits;
- Services and supplies furnished by an out-of-network provider or not listed as covered in the Progyny Member Guide;
- All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to laboratory tests, and
- Treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine.

Gender Affirming Care Services	In-Network	Out-of-Network
Mental Health Office Visit	$5 copayment / visit	Not Covered
Gender Affirming Voice Therapy	$15 copayment / visit	Not Covered
Gender Affirming Surgery	$170 to $3,500 copayment / visit	Not Covered
Gender Affirming Reconstructive Services	$25 to $170 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- The following services are covered for Gender Affirming Care:
  - Psychotherapy for Gender Dysphoria and associated comorbid psychiatric diagnoses.
  - Hormone therapy as appropriate to the patient's gender goals: Hormone therapy administered by a medical Provider (for example during an office visit). Hormone therapy dispensed from a pharmacy is provided as described under Section 13 (Attachment I – Outpatient Prescription Drugs).
  - Laboratory testing to monitor the safety of continuous hormone therapy as appropriate to the patient's gender goals.
  - Voice lessons and voice therapy.

- Members must be 18 years of age or older for the surgical treatment of Gender Dysphoria.
- Surgery treatment for Gender Dysphoria, includes the surgeries listed below:
- Procedures that may be performed in support of a gender affirming surgery, including skin grafts or flap surgery.
  - Abdominoplasty and body contouring
  - Gluteal augmentation
  - Dermatology
  - Hair removal
  - Hair transplantation
  - Liposuction
  - Genital surgeries:
    - Clitoroplasty (creation of clitoris)
    - Hysterectomy (removal of uterus)
    - Labiaplasty (creation of labia)
    - Metoidioplasty (creation of penis, using clitoris)
    - Orchiectomy (removal of testicles)
    - Penectomy (removal of penis)
    - Penile prosthesis
    - Phalloplasty (creation of penis)
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
    - Scrotoplasty (creation of scrotum)
    - Testicular prosthesis
    - Urethroplasty (reconstruction of female urethra)
    - Urethroplasty (reconstruction of male urethra)
    - Vaginectomy (removal of vagina)
    - Vaginoplasty (creation of vagina)
    - Vulvectomy (removal of vulva)
  - Chest surgeries:
    - Bilateral mastectomy or breast reduction
    - Breast enlargement, including augmentation mammoplasty and breast implants.
  - Face and neck surgeries:
    - Blepharoplasty (eyelid lift).
    - Brow lift.
    - Forehead lift.
    - Face lift.
    - Facial bone remodeling.
    - Facial feminization and masculinization.

  - Lip reshaping.
  - Rhinoplasty (nose reshaping).
  - Thyroid cartilage remodeling / thyroid chondroplasty.
  - Neck tightening.
  - Voice modification surgery.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Gender Affirming Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.

Home Health Services	In-Network	Out-of-Network
Home Health Care Visit	$70 copayment / visit	Not Covered
Private Duty Nursing	$70 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Home Health Care Visits are limited to 120 visits per Participant per Plan Year for in-network Providers.
- Private Duty Nursing does not have a limit.
- Services received from a Home Health Agency (an organization authorized by law to provide health care services in the home) or independent Provider that are the following:
  - Ordered by a Physician.
  - Provided in your home by a registered nurse or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
  - Provided on a part-time, intermittent care schedule.
  - Provided when skilled care is required.
- For Enteral Nutrition administered at home, multiple copayments will apply (such as for formula and nursing visit).
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Health Agency, will apply to the Home Health Services visit limits.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, not administered by a Home Health Agency will apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.

Hospice Care	In-Network	Out-of-Network
Home Hospice Visit	$70 copayment / visit	Not Covered
Inpatient Hospice Care	$3,500 copayment / stay	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill.
- Hospice care can be provided in the home or an inpatient setting and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Participant (terminally ill person) is receiving hospice care.
- Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.
- Inpatient Hospice Care may require Prior Authorization and Medical Necessity review.

Hospital Services — Other	In-Network	Out-of-Network
Outpatient Hospital Visit	$200 to $1,000 copayment / visit	Not Covered
Inpatient Hospital	$3,500 copayment / stay	Not Covered

NOTES:

- Other Hospital Services: The above copayments apply for Covered Health Services not specifically listed in this SPD, Surest mobile app or Benefits.Surest.com. Copayments may vary based in Provider and location.
- Refer to the Surest mobile app for additional coverage information.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Hospital Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest Copay Only Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Outpatient hospital care includes services such as radiation device placement, outpatient pulmonary function testing, esophageal dilation, and hip dysplasia treatment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

Laboratory Services, X-Rays, and Diagnostic Tests — Outpatient	In-Network	Out-of-Network
Non-Routine Tests	$25 to $1,300 copayment / visit	Not Covered
Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds	$0 copayment / visit	$0 copayment / visit*

* *Out-of-Network Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds copayments ordered by an in-network Provider will apply to the in-network out-of-pocket maximum when ordered by an in-network Provider.*

NOTES:

- Refer to the Surest mobile app for additional coverage information and the copayment that has been assigned to your procedure/service.
- Copayments for Non-Routine Tests may vary based on Provider, location, and procedure.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the facility service or surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services for illness and injury-related diagnostic purposes, received on an outpatient basis at a hospital, alternate facility, or in a Physician's office include:
  - Non-routine diagnostic testing including, but not limited to:
    - Angiography (Arteriography).
    - Cardiac Event Monitoring.
    - Coronary Calcium Score (Heart Scan).
- Cystometrogram (CMG).
- Diagnostic Hearing Exams and Testing
- Echocardiogram Exercise Stress Test.
- EKG Exercise Stress Test.
- Electroencephalogram (EEG).
- Electromyography (EMG) and Nerve Conduction Studies (NCS).
- Gastrointestinal Motility Testing.
- Genetic Testing.
- Home Sleep Test & Unattended Sleep Study.
- Attended Sleep Study (Polysomnography).
- Non-cardiac Angiography, Arthrography, and Myelography.
- Pulmonary Function Tests.
  - Tilt Table Testing.
  - Transthoracic Echocardiogram (TTE).
- Routine diagnostic testing such as:
  - Diagnostic labs, pathology tests, and interpretation charges, such as blood tests, analysis of tissues, or liquids from the body.
  - Diagnostic ultrasounds and X-rays, such as fluoroscopic tests and interpretation.
- If more than one type of imaging occurs, such as an x-ray and ultrasound, on the same date of service, more than one copayment may apply.
- If more than one type of diagnostic testing occurs, such as an EKG exercise stress test and an electroencephalogram (EEG), on the same date of service, more than one copayment may apply.
- The following categories of Genetic Testing services are covered:
  - Genetic tests for cancer susceptibility.

- Genetic tests for hereditary diseases.
- Unspecified molecular pathology.
- Fetal aneuploidy testing.

- Select Laboratory services and Diagnostic Testing may require Prior Authorization and Medical Necessity review.

Maternity Care and Delivery	In-Network	Out-of-Network
Routine Prenatal and Postnatal Office Visits, including Labs and Tests	$0 copayment / visit	Not Covered
Newborn Nursery Care	$0 copayment / test	Not Covered
Amniocentesis	$700 copayment / test	Not Covered
Chorionic Villus Sampling (CVS)	$650 copayment / test	Not Covered
Inpatient Delivery	$1,500 to $3,500 copayment / stay	Not Covered
Home Birth/Delivery	$1,200 copayment / visit	Not Covered
Non-Surgical Abortion — Medically Necessary	$150 copayment / visit	Not Covered
Surgical Abortion — Medically Necessary	$225 copayment / visit	Not Covered
Non-Surgical Abortion — Elective	$150 copayment / visit	Not Covered
Surgical Abortion — Elective	$225 copayment / visit	Not Covered
All Other Outpatient Services	Based on place of services	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- The copayments for inpatient delivery may vary based on Provider and location; this includes a birthing center.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Maternity Care and Delivery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a fetal monitor, may result in an additional copayment.
- Routine prenatal and postnatal maternity services include evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force and Health Resources and Services Administration.
- Home visit limited to one visit immediately following discharge of mother and newborn.
- Hospital visits or admissions that do not result in delivery including false labor and tests or services not considered “routine” will follow the inpatient or outpatient hospital services Benefit.
- There will be one copayment for all Covered Health Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copayment will apply to the baby’s services. See Hospital Services section for Benefits.
- Home Birth/Delivery copayment includes medical supplies used for a home delivery of an infant. Birthing tubs are not covered.
- Inpatient deliveries do not require Prior Authorization or notification unless the mother is hospitalized more than 48-hours following a normal vaginal delivery and 96-hours following a normal cesarean section delivery. Stays beyond these time periods may require Prior Authorization and Medical Necessity review.

Medical Infusions, Injectables, and Chemotherapy	In-Network	Out-of-Network
Cancer Chemotherapy	$45 to $620 copayment / visit	Not Covered
Provider Administered Drugs	$50 to $3,100 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- Copayments may vary based on Provider and location.
- Benefits are available for certain medical infusions, and injectables, and cancer chemotherapy administered on an outpatient basis in a hospital facility, alternate facility, in a Physician's office, or in the home. This includes intravenous chemotherapy or other intravenous infusion therapy.
- Covered Health Services include medical education services that are provided in an office, outpatient hospital, or alternate facility by appropriately licensed or registered health care professionals.
- The Medical Infusions and injectables require supervision and follow up with a medical professional. The Provider Administered Drugs will be dispensed and administered by a medical professional. Certain drugs are dispensed by a medical professional and may require special handling and storage. Certain drugs may require special handling and storage and are generally considered Specialty Drugs administered by a medical professional.
- Supportive drugs that are often unplanned for your diagnosis and treatment, such as IV fluids or antibiotic injections, have a $0 copayment.
- Provider Administered Drugs and Cancer Chemotherapy that are typically for planned administration have their own copayments when given in a non-emergent outpatient setting. If a mixture of drugs is needed for a chemotherapy visit, the copayment of the highest cost drug will apply to that visit.
- The copayments apply to specific drugs that must be administered in a medical setting or under medical supervision. Call Surest Member Services to learn which medical drug (e.g., infusions and injections) are subject to these copayments.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Medical Drug copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Select injectable drugs that can be safely self-administered may not be covered under the medical Benefit. These drugs or equivalent drugs are covered under the pharmacy Benefits.
- Select Medical Infusions, Injectables, and Chemotherapy may require Prior Authorization and Medical Necessity review.

Obesity Treatment

Surgical treatment of obesity is only available to covered Employees and Dependents who:

- Are age 12 or older;
- Completed and documented a 3-month supervised weight loss program prior to surgery;
- Have a BMI (body mass index) of 37.5 kg/m2 or greater; or have a minimum BMI of 32.5 kg/m2 with complicating comorbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity;
- Go through a United Bariatric Resource Network Center of Excellence facility; and

Complete the pre-notification process prior to surgery through a United Resource Network Center of Excellence.

Office Visit and Diagnostic Visit	In-Network	Out-of-Network
Office Visit (including Telehealth Visit)	$25 to $130 copayment / visit	Not Covered
Mental Health Office Visit (including Telehealth Visit)	$25 copayment / visit	Not Covered
Allergy Injection Visit	$0 copayment / visit	Not Covered
Allergy Testing and Treatment	$170 copayment / visit	Not Covered
Convenience Care / Retail Visit	$0 copayment / visit	Not Covered
E-Visit and Telephone Consult with Your Physician	$25 copayment / visit	Not Covered
Outpatient Anticoagulant Management	$20 copayment / visit	Not Covered
Travel Vaccines	$0 copayment / visit	Not Covered
Virtual Care	See Virtual Care section for virtual visit details	Not Applicable

NOTES:

The Surest Plan provides Benefits for services provided in an office for the diagnosis and treatment of an illness or injury.

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Office Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Office Visit refers to face-to-face visit or Telehealth Visit with your Provider.
- Multiple copayments may apply if a treatment or procedure is also performed during a visit.
- Hearing Services — Assessments with your Provider.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Virtual Care refers to a visit with a Designated Virtual Network Provider such as Doctor on Demand. See Virtual Care Section for details.
- Convenience Care/Retail Clinics are walk-in clinics in retail stores, supermarkets, and pharmacies that treat uncomplicated minor illnesses and injuries, and provide preventive care services.
- If your Provider refers you for a test or service within a hospital or other facility, the Outpatient Hospital copayment may apply.
- Returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Palliative Care	In-Network	Out-of-Network
Office Visit	$25 to $130 copayment / visit	Not Covered
Home Health Care Visit	$70 copayment / visit	Not Covered
Outpatient Hospital Visit	$200 to $1,000 copayment / visit	$630 copayment / visit

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- The Surest Copay Only Plan provides Benefits for palliative care for Participants with a new or established diagnosis of progressive debilitating illness.
- Includes services for pain management received as part of a palliative care treatment plan.
- The services must be within the scope of the Provider's license to be covered.
- Select services performed in the office and outpatient hospital setting may require Prior Authorization and Medical Necessity Review.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- See Home Health Services notes for services related to Home Health Care.
- See Hospice Care notes for services related to Hospice.

Preventive Care Services	In-Network	Out-of-Network
Preventive Care Services	$0 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Preventive Care Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Services include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration, and Advisory Committee on Immunization Practices.
- Examples include:
  - Pediatric preventive care services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations up to age 18.
  - Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once-a-year visits from 24 months to age six.
  - Routine physical exams.
- Routine screenings for certain cancers and other conditions. This includes mammography, breast ultrasounds and breast MRIs.
  - Routine screening colonoscopy is covered as preventive with a diagnosis of family history.
  - Routine immunizations. Age limits may apply.
  - Routine lab tests, pathology, and radiology.
  - Hearing exams do not have a limit.
  - Routine pre-natal and post-natal services.
  - One routine postnatal care exam provided during the period immediately after childbirth that includes a health exam, assessment, education, and counseling.
  - Preventive contraceptive methods and counseling for women.
  - Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.

- For Prescription Drug Coverage see Section 13 (Attachment I — Outpatient Prescription Drugs).
- Low-dose CT Scan (LDCT) for lung cancer screening may require Prior Authorization and Medical Necessity review.

Radiation Therapy and Other High Intensity Therapy	In-Network	Out-of-Network
	$70 to $2,800 copayment / visit	Not Covered

NOTES:

- The Surest Copay Only Plan provides Benefits for services received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.
- Refer to the Surest mobile app for additional coverage information and the copayment assigned to your procedure/service.
- Copayments for Radiation Therapy and Other High Intensity Therapy may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Radiation Therapy copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Benefits include Physician services and facility charges, and services such as, but not limited to:
- Actinotherapy.
- Apheresis.
  - Blood Transfusion.
  - Brachytherapy.
  - Conventional External Beam Radiation Therapy (EBRT).
  - Hyperbaric Oxygen Therapy (HBOT).
  - Non-Oral Radiopharmaceutical Therapy.
  - Oral Radiopharmaceutical Therapy.
  - Proton Therapy.
  - Radiation Therapy Simulation and Planning.
  - Radiopharmaceutical Therapy.
  - Stereotactic Radiation Therapy.
- Select Radiation Therapies may require Prior Authorization and Medical Necessity Review.
- See notes under Hospital Services Other for services related to Radiation Device Placement.
- See Dialysis Services for services for dialysis and home.

Reconstructive Surgery	In-Network	Out-of-Network
Office Visit	$25 to $130 copayment / visit	Not Covered
Outpatient Hospital	$200 to $1,000 copayment / visit	Not Covered
Inpatient Hospital	$3,500 copayment / stay	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.

- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Reconstructive Surgery copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an illness, injury, or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.
- Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.
- Benefits for Reconstructive procedures include breast reconstruction following a mastectomy and Reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Surest Plan if the initial breast implant followed a mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Services. You can contact Surest Member Services at the number on your member ID card for more information about Benefits for mastectomy-related services.
- There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic procedures. An example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive procedure. In other cases, if improvement in appearance is the primary intended purpose, this would be considered a Cosmetic procedure. The Surest Plan does not provide Benefits for Cosmetic services or procedures.
- The fact that a Participant may suffer psychological consequences or socially avoidant behavior as a result of an illness, injury, or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as Reconstructive procedures.
- Reconstructive Surgery may require Prior Authorization and Medical Necessity review.

Rehabilitative/Habilitative Services and Other Low Intensity Therapy	**In-Network**	**Out-of-Network**
Acupuncture Visit	$60 copayment / visit	Not Covered
Aural Therapy – Post Cochlear Implant	$25 to $165 copayment / visit	Not Covered
Cardiac Rehabilitation Therapy	$70 copayment / visit	Not Covered
Chiropractic Visit	$30 copayment / visit	Not Covered
Cognitive Therapy	$15 to $115 copayment / visit	Not Covered
Occupational Therapy	$15 to $115 copayment / visit	Not Covered
Physical Therapy	$15 to $90 copayment / visit	Not Covered
Speech Therapy	$15 to $115 copayment / visit	Not Covered
Pulmonary Rehabilitation Therapy	$100 copayment / visit	Not Covered
Vision Therapy	$25 copayment / visit	Not Covered
NOTES:		

Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Benefits include services provided in a Physician's office or on an outpatient basis at a hospital, or alternate facility. Services provided in your home are provided as described under the Home Health Care section.

- Refer to the Surest mobile app for additional coverage and copayment information.
- The copayments for certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupational, physical, and speech therapy).
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Rehabilitative/Habilitative Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Acupuncture is limited to 30 visits Per Participant per Plan Year.
- Aural Therapy is limited to 30 visits per Participant per Plan Year.
- Chiropractic Visits are limited to 30 visits or services per Participant per Plan Year.
  - Chiropractic Services are limited to manipulative services including chiropractic care and osteopathic manipulation rendered to diagnose and treat acute neuromuscular-skeletal conditions.
- Cognitive, Occupational and Physical therapy visits are limited to a combined 75 visits per Participant per Plan Year.
  - Cognitive rehabilitation therapy following traumatic brain Injury or cerebral vascular accident is covered when Medically Necessary.
- Pulmonary Rehabilitation does not have visit limits.
- Speech therapy is limited to 75 visits per Plan Year.
- Therapies provided in the home will be assigned the home health care visit copayment. See Home Health Services for coverage notes.
- Note that Occupational Therapy and Physical Therapy are different types of services and the copayment varies based on how the claim is billed.
- Therapies related to the treatment of a mental health condition, such as autism disorder, are provided under Behavioral Health — Mental Health and Substance Use Disorder services section and do not apply to limits in this section.
- Vision therapy is limited to a lifetime max of 30 visits.

Skilled Nursing Facility Services	In-Network	Out-of-Network
Skilled Nursing Facility	$3,500 copayment / stay	Not Covered
Inpatient Rehabilitation Facility	$2,000 copayment / stay	Not Covered

NOTES:

- The Surest Copay Only Plan provides Benefits for services provided during an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.
- Refer to the Surest mobile app for additional coverage information.
- Skilled Nursing Facility stays are limited to 60 days per Participant per Plan Year.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Skilled Nursing Facility Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.

- An Inpatient Rehabilitation Facility, such as a long-term acute rehabilitation center, a hospital, or a special unit of a hospital designated as an inpatient rehabilitation facility, that provides occupational therapy, physical therapy, and/or speech therapy as authorized by law.
- Benefits include:
  - Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.
  - Supplies and non-Physician services received during the inpatient stay.
  - Room and board in a semi-private room (a room with two or more beds).
  - Physician services for anesthesiologists, pathologists, and radiologists.
  - Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an illness or injury that would have otherwise required an inpatient stay in a hospital.
- Benefits are available only if both of the following are true:
  - The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital.
  - You will receive skilled care services that are not primarily Custodial Care.
- Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
  - Services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
  - Services are ordered by a Physician.
  - Services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
  - Services require clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Surest Copay Only Plan does not provide Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12 (Glossary).
- Returning home from a Skilled Nursing Facility or Inpatient Rehabilitation Facility stay with durable medical equipment, such as a walker, may result in an additional copayment.
- All Skilled Nursing Facility and Inpatient Rehabilitation Facility admissions require Prior Authorization and Medical Necessity review.
- See Hospital Services for other coverage notes.

Transplant Services	In-Network	Out-of-Network
Bone Marrow and Solid Organ Transplant	$5,000 copayment / visit	Not Covered
Corneal Transplant	$5,000 copayment / visit	Not Covered
Cellular and Gene Therapy	$5,000 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Copayments for outpatient hospital visits may vary based on Provider and location.

- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Transplant Services copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Transplants for which Benefits are available include bone marrow (including CAR T-cell therapy for malignancies), heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and cornea.
- Benefits are also available for cellular and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility.
- Benefits are also available for CAR T and non-genetic cellular therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility. Note this Benefit excludes the gene therapies as described in Section 6 (What Is Not Covered). Benefits for CAR T therapy for malignancies are provided as described above.
- Surest has identified quality Designated Providers for transplant services (except for corneal transplant) that are accessible through Transplant Resource Services. See Section 5.4 (Clinical Programs and Resources) for additional information. Transplant services (except for corneal transplant) must be rendered at a Designated Provider.
- All Participants undergoing transplant services (except for corneal transplant) must enroll in Transplant Resource Services, which is a care coordination program for patients undergoing transplants.
- Benefits are available to the donor and the recipient when the recipient is covered under the Surest Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage.
- Surest has specific guidelines regarding Benefits for transplant services. Contact Surest Member Services at the number on your member ID card for information about these guidelines.
- The Transplant Resource Services program provides Benefits for travel and lodging expenses. See Complex Medical Conditions Travel and Lodging Assistance Program described in Section 5.4 (Clinical Programs and Resources) for more information.

Treatment / Tests / Therapies — Go to Surest mobile app or Benefits.Surest.com for additional information	**In-Network**	**Out-of-Network**
Level 1: Generally, minor procedures or treatments that are typically performed in an outpatient office setting (e.g., biofeedback, needle biopsy, pain management procedures, etc.)	$40 to $3,250 copayment / visit	Not Covered
Level 2: Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, glaucoma surgery, etc.)	$100 to $5,000 copayment / visit	Not Covered
Level 3: Generally, major procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting but may be performed in an inpatient hospital setting (e.g., thyroid surgery, prostate surgery, etc.)	$350 to $5,000 copayment / visit / stay	Not Covered
Level 4: Generally, major procedures, surgeries, or treatments that are typically performed in an inpatient hospital but may be performed in an outpatient hospital setting (e.g., colon surgery, small bowel surgery, etc.)	$450 to $5,000 copayment / visit / stay	Not Covered
Level 5: Generally, major procedures, surgeries, or treatments that require intensive monitoring and are performed in an inpatient hospital setting (e.g., bone marrow and solid organ transplant, brain tumor surgery, coronary artery bypass graft surgery, etc.)	$1,600 to $5,000 copayment / visit / stay	Not Covered
Other Treatments/Tests/Therapies: Refer to the Surest mobile app or Benefits.Surest.com website for coverage and copayment information or call Surest Member Services. Copayments may vary based on Provider, location and treatment, test, or therapy.		

Office Visits	$25 to $130 copayment / visit	Not Covered
Outpatient Hospital Visit	$200 to $1,000 copayment / visit	Not Covered
Inpatient Hospital	$3,500 copayment / stay	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- The copayments above apply unless a Benefit is specified in another section of this SPD, Surest mobile app or Benefits.Surest.com.
- Copayments for outpatient hospital visits may vary based on Provider and location.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Treatment / Tests / Therapies copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- Treatment, tests, and therapies have been tiered based on type and level (minor vs. major) of care. Some minor treatments or procedures are either included in the office visit copayment or may have a specific copayment based on the Provider and location selected. Some surgical procedures also have specific copayments based on the Provider or location selected.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Copayments for Procedures in Level 1 – Level 5 may vary based on Provider and location. Refer to the Surest mobile app or call Surest Member Services to determine the copayment assigned to your procedure/service.
  - Level 1 is a category of minor procedures typically performed in an outpatient office setting.
  - Level 2 is a category of minor surgeries and procedures or services typically performed in an outpatient hospital setting.
  - Level 3 is a category of major surgeries and procedures typically performed in an outpatient hospital setting.
  - Level 4 is a category of major surgeries and procedures typically performed in an inpatient hospital setting.
  - Level 5 is a category of major surgeries and procedures that require intensive monitoring and typically performed in an inpatient hospital setting. Transplant services must be rendered at a location specified as a Designated Provider.
- Bariatric Surgery does not have a limit.
- Biofeedback therapy is a non-drug treatment in which patients learn to control bodily processes that are normally involuntary, such as muscle tension, blood pressure, or heart rate.
- Copayments for office visits or outpatient hospital visits may vary based on Provider and location. Refer to the Surest mobile app or call Surest Member Services to determine the copayment assigned to your procedure/service.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Surest Copay Only Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or Observation Stay copayment will be waived, and you will be responsible for the Inpatient Hospital Services copayment.
- Returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Select office-based and outpatient procedures may require Prior Authorization and Medical Necessity review.

Urgent Care	In-Network	Out-of-Network
Urgent Care Visit	$50 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Benefits include visits at a walk-in Urgent Care center that treats illnesses and injuries requiring immediate care, but not serious enough to require an Emergency department visit.
- Routine diagnostic services, including diagnostic lab, x-ray, and ultrasound are included in the Urgent Care Visit copayment. When the routine diagnostic service is prescribed by a doctor and received on a different date of service and location, the service is $0 copayment.
- If the Urgent Care facility is unable to treat you, you may be referred to the Emergency Room or other Provider, you will be responsible for both the Urgent Care and Emergency Room Copayments.
- Returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

Virtual Care — Designated Provider	In-Network	Out-of-Network
Virtual Primary and Urgent Care	$0 copayment / visit	Not Covered
Virtual Mental Health and Substance Use Disorder Care	$25 to $90 copayment / visit	Not Covered
Virtual Specialty Care	$0 to $130 copayment / visit	Not Covered

NOTES:

- Refer to the Surest mobile app for additional coverage information.
- Please see the Behavioral Health and Office Visit sections for additional information on Telehealth Visits with your Provider.
- Virtual care is for Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually within the scope of practice of the virtual providers, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides communication of medical information between the patient and a Provider, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).
- Copayments will vary based on Provider. If you choose a Provider that is not a member of the Designated Virtual Provider Network, see Office Visit section for additional Telehealth Visit copayment information. Benefits are available only when services are delivered through a Designated Virtual Network Provider that are specified by your Surest Plan.

- Please visit the Surest mobile app or Benefits.Surest.com or call Surest Member Services to locate a Designated Virtual Network Provider.
- No virtual care coverage for out-of-network Providers.
- Please note that not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which in-person Physician contact is needed.

Travel and Lodging for Covered Health Services

The Transplant Resource Services program provides Benefits for travel and lodging expenses. See Travel and Lodging Assistance Program described in Clinical Programs and Resources for more information.

The Plan provides a Participant with a travel and lodging allowance related to the Covered Health Service when a network provider is not available within 50 miles from their address.

Travel and Lodging provides support for the Participant under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Participant and travel companion when the Participant must travel at least 50 miles from their address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Participant. A lifetime maximum of up to $10,000 will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. This maximum is combined with the Complex Medical Conditions — Travel and Lodging Assistance Program in Section 5.4 (Clinical Programs and Resources). Lodging expenses are further limited to $50 per day for the Participant, or $100 per day for the Participant with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, see Benefits.Surest.com or contact Surest Member Services.

Clinical Trials

Clinical trials are research studies designed to find ways to improve health care or to improve prevention, diagnosis, or treatment of health problems. The purpose of many clinical trials is to find out whether a medicine or treatment is safe and effective for treating a certain condition or disease. Clinical trials compare the effectiveness of medicines or treatments against standard, accepted treatment, or against a placebo if there is no standard treatment.

Participants in clinical trials are typically randomized to different treatment arms and based on that randomization may receive either the study intervention or the control intervention.

Services provided in a clinical trial typically include the interventions being evaluated (study agent and control agent) and other clinical services required to evaluate the effectiveness and safety of the interventions being compared.

In compliance with federal law, your Benefits cover routine health care costs for qualifying individuals participating in an approved clinical trial. For more information call Surest Member Services at the number on your member ID card.

Clinical Trial services may require Prior Authorization and Medical Necessity review.

Prior Authorization and Pre-Admission Notification

Select services require Prior Authorization or Pre-Admission Notification. Prior Authorization is required by service type, regardless of whether the service is rendered by in-network or out-of-network Providers.

In-network Providers are responsible for obtaining Prior Authorization for select Covered Health Services and are responsible for Pre-Admission Notification for planned inpatient admissions and post-admission notification at least 24 hours of admission of Emergency inpatient admissions. Inpatient stays will be reviewed for Medical Necessity, length of stay, and level of care. All acute inpatient rehabilitation (AIR) admissions, long-term acute care (LTAC) admissions, and Skilled Nursing Facility (SNF) admissions are subject to Medical Necessity review pre-admission. If you have questions about Prior Authorization or Pre-Admission Notification, please contact Surest Member Services.

If you are using an out-of-network Provider, you are responsible for ensuring that any necessary Prior Authorizations and Pre-Admission Notifications have been obtained or the services may not be covered by the Surest Plan. Only certain out-of-network

Covered Health Services are available for Benefits (e.g., ambulance, Emergency room). Contact Surest Member Services prior to obtaining services to determine whether Prior Authorization is required or ask your Provider to contact the pre-certification number on your member ID card.

If your Prior Authorization or Pre-Admission Notification is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). This information can also be found in Section 8 (What Do I Do If My Claim Is Denied).

The Prior Authorization list is subject to change without notice. The most current information can be obtained by having your Provider contact the pre-certification number on your member ID card or call Surest Member Services.

Prior Authorization may be required for but is not limited to the following services:

- Acute care hospitalizations (planned)
- Acute inpatient rehabilitation
- Applied behavioral analysis
- Non-Emergency air transportation
- Bariatric surgery
- Bone growth stimulators
- BRCA testing
- Select cardiovascular procedures
- Select chemotherapy
- Clinical trials
- Cochlear implant surgery
- Potentially Cosmetic and Reconstructive surgery
- Select durable medical equipment, orthotics, and prosthetics
- Select genetic and molecular tests
- Select injectable medications
- Intensity-modulated radiation therapy
- Long-term acute care
- MR-guided focused ultrasound
- Organ transplants
- Orthognathic surgery
- Partial hospitalization
- Private Duty Nursing
- Proton beam therapy
- Residential treatment facilities
- Skilled Nursing Facilities
- Sleep apnea procedures
- Sleep studies
- Select spinal surgeries
- Vein procedures
- Ventricular assist devices

Clinical Programs and Resources

Surest Care Management

Surest Care Management offers support to help you use your Benefits, improve your health, and achieve an optimal quality of life.

Surest care managers act as an advocate for you and your family by:

- Assisting you in making important health care decisions.
- Coordinating your care with your health care Providers.
- Helping you develop self-management skills.
- Identifying available treatment options.
- Offering personalized coaching to help you live better with an illness or recover from an acute condition.
- Researching resources, such as Digital Health Solutions (see below), support groups, and financial assistance.

Although your care manager will be your primary program contact, you and your Physician will always make the decisions about your treatment. By working closely with your Physician and using the resources available in your community, this program can help you through a difficult time.

It is your choice to participate in Surest Care Management. There are no extra charges for these services, and you can end your participation at any time, for any reason. Participation in this program will not affect your Benefits. Contact Surest Member Services if you think you can use this support.

Surest Digital Health Solutions

Surest Digital Health Solutions are programs offered by Surest to provide health-related services that prevent, treat, or reverse one or more chronic diseases or conditions. Services may include education, decision-support, coaching, nutritional support, caregiver support, meditation, therapeutic movement, and other therapeutic or diagnostic services that would not otherwise be considered Medically Necessary, or may be excluded Benefits, if provided outside of Surest Digital Health Solutions.

Surest may offer additional or varying Digital Health Solutions throughout the year. To find out additional information, visit the Surest mobile app or Benefits.Surest.com website or call Surest Member Services.

Kaia Health

Kaia is a digital therapy app for various fitness levels and lifestyles. Kaia offers a personalized therapy program that addresses both the causes and symptoms pain. Surest has partnered with Kaia to offer you and your dependents access to Kaia at no additional cost. When you sign up with Kaia, you'll immediately gain access to their clinically validated therapy, including:

- Personalized exercises.
- One-on-one coaching.
- Whole-person mind-body training.
- Wellness education.
- Advanced motion analysis technology.

Learn more about Kaia and sign up at www.startkaia.com/surest.

Complex Medical Conditions, Programs and Services

Bariatric Resource Services (BRS)

Bariatric Resource Services provides you with access to a team of clinical experts who specialize in weight loss and bariatric surgery. You will receive complete support before, during and after bariatric surgery.

Bariatric Resource Services nurses can help:

- Answer questions.
- Find Focused High-Performing BRS Network providers to make sure surgery goes as smoothly as possible.
- Learn about surgical options for best possible outcomes.
- Find resources to help you meet your pre-surgical requirements.
- Understand how nutrition and fitness can help achieve success.
- Adjust to and maintain lifestyle changes and avoid complication after surgery.

You must enroll in the program for coverage. Enroll at 1-888-936-7246, extension 38315 or Option 5.

Cancer Resources Services

Connect with a nurse specially trained in oncology to help you make the right decisions for your health. The nurse can help you understand your condition and treatment options and also assist in finding in-network Providers, which may include a Center of Excellence facility recognized for delivering high-quality care and results. The Cancer Centers of Excellence network provides access to best-practice cancer care for complex, hard-to-treat and hard-to-diagnose cancers. The Cancer Resources Services (CRS) network of cancer centers identifies best practice cancer programs throughout the U.S.

Comprehensive Kidney Solution (CKS) program

For Participants diagnosed with Kidney Disease, the Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) Stage 4/5 through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a “best practices” approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Congenital Heart Disease Resource Services

Because Congenital Heart Disease (CHD) care is complex, covered Surest Participants with CHD have access to a CHD Resources Service that can help you locate CHD Centers of Excellence Providers and best practice CDH programs throughout the U.S. A nurse can work with you to help you:

- Identify the CHD hospital options for you, including Centers of Excellence.
- Evaluate your needs for information and support before and after a CHD treatment.
- Understand your benefits and provide resources to help you navigate the health system to make sure you and your Participants get the care you need.

Disease Management Program

Condition management includes managing COPD, coronary artery disease and heart failure.

- Helps members improve self-care, identify warning signs and access resources for assistance, with the goal of reducing the need for urgent/emergency services.
- Reinforces and supports physician treatment plans.

- Helps members prepare for physician visits so they may get the most out of their care encounters.
- May help eliminate unnecessary or redundant procedures, reduce complication rates and improve medical outcomes.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

Transplant Resource Services

For a solid organ and blood/marrow transplant to be a Covered Health Service, you must be enrolled in Transplant Resource Services and use a designated provider. Most transplants are expensive and complicated. At Surest, we ensure you are going to a reputable facility that has expertise in the specific type of transplant you need. Contact Surest Member Services at the number on your member ID card for more information on Transplant Resource Services and access to designated providers.

Once you are enrolled in Transplant Resource Services, a dedicated nurse case manager who specializes in transplant cases will provide assistance in:

- Selecting the transplant facility.
- Scheduling your evaluation at the transplant facility.
- Following up with you routinely while you are on the transplant list.
- Discharge planning, post-transplant support, and ongoing help with your care needs.

Organs included in the program are heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and bone marrow (blood forming stem cell transplants). While corneal transplant is a solid tissue transplant, it is not considered part of the Transplant Resource Services program.

The Transplant Resource Services provides Benefits for travel and lodging expenses. See Complex Medical Conditions Travel and Lodging Assistance Program described in this section for more information.

Travel and Lodging Assistance Program

T-Mobile may provide you with Travel and Lodging assistance for following categories:

- Congenital Heart Disease Services (CDH);
- Gender Affirming Care;
- Spina Bifida;
- Fertility Treatment;
- Hospice;
- Clinical Trials: Travel assistance for clinical trials (if not included with cancer treatment);
- Cancer Treatment;
- Mental Health/Substance Abuse;
- Cellular Immunotherapy and Gene Therapy;
- Reproductive Health Services;
- Obesity Treatment;
- Organ / Tissue Transplant; and

- Other covered medical or mental health treatment that requires traveling to or staying near a treating facility that is more than 50 miles from home.

Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

There is a combined $10,000 lifetime limit for all conditions eligible for travel and lodging assistance.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call Surest Member Services.

Travel and Lodging assistance is covered in-network only unless it is for Gender Affirming Care

If you have specific questions regarding the Travel and Lodging Assistance Program, please call Surest Member Services.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the Participant and a travel companion as follows:

- Transportation of the Participant and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below.
- The eligible expenses for lodging for the Participant (while not a hospital inpatient) and one companion.
- If the Participant is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Participant resides at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Participant and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Participant for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures. This maximum is combined with the Travel and Lodging for Covered Health Services at the end of Section 5.1 (Covered Health Services).

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The reimbursement limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be construed as tax advice.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the in-network Provider or Designated Provider.
- Taxi, Uber/Lyft fares (not including limos or car services / rental cars).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Which Travel and Lodging transportation expenses are covered?

- Rental car and fuel

  - If your car rental receipt does not clearly show a daily rate, the rental bill will be divided by the total number of days of the rental to get a daily rate
- Personal car and fuel
- Mileage
- Domestic Airfare for economy/coach tickets
  - Domestic airfare other than economy or coach and international airfare is not reimbursable
- Train, bus, ferry, and subway fares
- Taxi, Uber, Lyft fares
  - Limos and car services are not covered
- Parking fee and tolls

Which Travel and Lodging expenses are not covered?

Reimbursement is not available for (but is not limited to) the following:

- Groceries
- Meals/Beverages
- Over-the-counter dressings, medical supplies
- Personal care items or cleaning supplies
- Phone calls, newspapers, movie rentals or other entertainment expenses
- Tips
- Other expenses not included under the covered items indicated as covered above

Other Condition Focused Programs Made Available by T-Mobile USA, Inc.

2nd.MD Second Opinion Service

The Plan offers a second opinion service. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card or www.2nd.md/activate/step1/surest/.

Transition of Care and Continuity of Care

If you are new to the Surest Copay Only Plan and are actively receiving treatment from a Provider who is not in our network, you may be eligible to receive Transition of Care Benefits. Transition of Care Benefits allow you the option to request coverage from your current out-of-network Provider at in-network copayments for a limited time due to a qualifying medical condition until the safe transfer to an in-network Provider can be arranged. Transition of Care Benefits are managed on a case-by-case basis.

If you are currently covered by the Surest Copay Only Plan and your health care Provider leaves the network, you can apply for Continuity of Care. If you have medical reasons preventing immediate transfer to a network provider, Continuity of Care Benefits will allow you the option to request extended care from your out-of-network Provider while paying in-network copayments until a safe transition can be made to an in-network Provider. Continuity of Care Benefits are managed on a case-by-case basis.

If you are currently receiving treatment for Covered Health Services from a Provider whose network status changes from in-network to out-of-network during such treatment due to termination (non-renewal or expiration) of the Provider's contract, you may be eligible to request continued care from your current Provider under the same terms and conditions that would have applied prior to termination of the Provider's contract for specified conditions and timeframes. This provision does not apply

to Provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, call Surest Member Services for assistance.

The following criteria must be met for your Transition of Care or Continuity of Care application to be considered:

- **Transition of Care**: You are newly eligible for the Surest Copay Only Plan and currently receiving care for a Covered Health Service by an in-network Provider and your Provider is no longer in-network under the Surest Copay Only Plan.
- **Continuity of Care**: You are currently enrolled in the Surest Copay Only Plan and actively receiving care for a Covered Health Services by an in-network Provider, who subsequently leaves the network and becomes an out-of-network Provider.

In addition, you must have at least one of the following:

- **Inpatient and Residential Care:** If you are actively receiving inpatient or residential care at a Provider that was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits to cover the duration of the inpatient or residential care stay.
- **Recent Major Surgery:** If you have had a recent surgery or procedure with an in-network provider who becomes out-of- network, are in the acute phase and follow-up period (generally six to eight weeks after surgery) you may qualify for Transition of Care or Continuity of Care.
- **Scheduled Surgery/Procedure:** If you are scheduled to undergo a nonelective surgery or procedure with an in-network Provider who becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits. Surest
- **Pregnancy:** If you are pregnant and receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care and Continuity of Care Benefits.
- **Serious Chronic Condition:** If you are actively being treated for a serious chronic medical condition which may persist or worsen if care is delayed and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care and Continuity of Care Benefits.
- **Terminal Illness:** If you have an incurable or irreversible condition that has a probability of causing death within one year or less and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care and Continuity of Care Benefits.
- **Transplant:** If you are a transplant candidate or the recipient of an organ transplant and in need of ongoing care due to complications associated with the transplant and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care and Continuity of Care Benefits.

To request an application for Transition of Care (new Participants) or Continuity of Care (existing Participants), call Surest Member Services at the number on your Surest member ID card. Applications are also available on Benefits.Surest.com. The application must be completed and returned within 30 days of the Effective Date of coverage for new Participants or within 30 days of the Provider leaving the network for existing Participants. After receiving your request, Surest will review and evaluate the information provided and send you a letter to let you know if your request was approved or denied. A denial will include information about how to appeal the determination.

- If your request is approved for the medical condition(s) listed on your application(s), you will receive the network level coverage for treatment of the specific condition(s) by the Provider for:
  - Up to 30 days from the effective date of coverage for new members for medical services,
  - Up to 90 days from the effective date of coverage for new members for behavioral health services,
  - Up to 90 days from when your provider leaves your health plan network, or
  - Through completion of the current active course of treatment period, whichever comes first.

WHAT IS NOT COVERED

The Surest Plan does not provide Benefits for the following services, treatments, or supplies (including items or services that are related to the services, treatments, or supplies listed below, but which are not specifically listed below) even if they are

recommended or prescribed by a Provider or are the only available treatment for your condition, unless specifically described or listed in Section 5.1 (Covered Health Services).

This Plan will not pay or approve benefits for any of the services, supplies, items, or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies received before an Employee or their Dependent becomes covered under this Plan.
- Services or supplies received after the date an Employee or their Dependent's coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under this Plan. (An Employee may not be enrolled as both an Employee and a Dependent under the Plan.).
- A procedure or surgery to remove fatty tissue such as panniculectomy (except when medically necessary), abdominoplasty, thighplasty, brachioplasty, or mastopexy.
- Orthotic appliances and devices, except when all of the following are met:
  - Prescribed by a Physician for a medical purpose; and
  - Custom manufactured or custom fitted to an individual Covered Person.

    NOTE: *Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics, cranial bands, or any braces that are obtained without a Physician's order. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.*
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Chelation therapy, except to treat heavy metal poisoning.
- Any charges for completion of claim forms, missed appointments, room or facility reservations or record processing.
- Any charge for services, supplies or equipment advertised by the provider as free.
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency. Any charges prohibited by a federal anti-kickback or self-referral statues.
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
- Breast reduction surgery that is determined to be a Cosmetic Procedure, except those provided for Gender Affirming Care. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures.
- Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.
  - Care that meets one of these conditions is custodial care regardless of any of the following:
    - Who recommends, provides, or directs the care;
    - Where the care is provided; or
    - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Domiciliary care.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

- Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. .
  - This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials*
- Eyeglasses, contact lenses, eye refractions, unless required due to an accidental injury or cataract surgery (the Plan covers only the first pair of glasses or contact lens following cataract surgery). Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
- Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.
- Health services for which you have no legal responsibility to pay and for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Herbal medicine, holistic or homeopathic care, including drugs, however the Covered Health Services of naturopathic physicians are covered services.
- Services, supplies, medical care, or treatment given by a family member by birth or marriage, including:
  - The Employee's Spouse; and
  - The Child, brother, sister, parent, or grandparent of either the Employee or the Employee's Spouse.

  NOTE: *This includes any service the provider may perform on himself or herself. This also includes in-laws and step relatives.*
- Services performed by a provider with the same legal residence.
- Services performed at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service; or
  - Is not actively involved in your medical care after the service is received.

  NOTE: *This exclusion does not apply to mammography testing.*
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided under Reconstructive Procedures or Gender Affirming Care.
- Surgical correction or other treatment of malocclusion. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or if required due to cancer. Orthognathic surgery and jaw alignment, except as treatment of obstructive sleep apnea. Medically necessary reconstructive Orthognathic Surgery is covered. Orthognathic services that are considered cosmetic are excluded. Services or supplies that are not Covered Health Services, including any confinement or treatment given in connection with a service or supply which is not Covered Health Services.
- Massage therapy, including any services provided by a Massage Therapist.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Medical and surgical treatment of excessive sweating (hyperhidrosis), except Botox.
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Snoring appliances.

- Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to Benefits provided under *Non-Preventive Nutritional Counseling*.

  NOTE: *Obesity-related nutritional counseling is covered as preventive.*

- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
- For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, and hot tubs.
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career (except for vaccines or immunizations required for T-Mobile work-related travel), education, sports or camp, employment, insurance, marriage, or adoption; or
  - Conducted for purposes of medical research; or
  - Related to judicial or administrative proceedings or orders unless Medically Necessary; or
  - Required to obtain or maintain a license of any type.
- Private duty nursing services while confined in a facility.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
- Health services for organ and tissue transplants, except those described in Other Services and Supplies. Health services for transplants involving animal organs. Multiple organ transplants not listed as a Covered Health Service under Organ/Tissue Transplants under Other Services and Supplies, unless determined by the medical claims administrator to be a proven procedure for the involved diagnosis/diagnoses.
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under this Plan and is undergoing a covered transplant.
- Respite care; this exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under ***Hospice Care***.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging or elsewhere in this SPD.
- Stand-by services required by a Physician.
- Except as defined under Orthognathic Surgery, care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, orthodontia, extractions, implants, or any treatment to improve the ability to chew or speak. See Other Services and Supplies for limited coverage of oral surgery and dental services.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Special foods, food supplements, liquid diets, diet plans or any related products, unless allowed under the Nutritional Supplements/Enteral Feeding provision.

- Services for the evaluation and treatment of Temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances.
- Weight loss surgery for individuals under age 18.
- Weight loss treatment (except as a part of the Obesity Surgery benefit).
- Wigs or toupees (except for medically induced hair loss in all diagnosed situations), hair transplants, or hair weaving.
- Services given by volunteers or persons who do not normally charge for their services.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing, treatment of non-specific candida sensitivity and urine auto injections.
- Services provided to someone other than the ill or injured member. This includes health care provider training or educational services.
- Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*.
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Transitional Living services (including recovery residences).
- Non-medical 24-hour withdrawal management, , providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
- Residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment. Treatment in wilderness programs or other similar programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution), except for that portion of treatment that would otherwise be eligible health services under this Plan (e.g., individual counseling).
- Expenses for health services and supplies that exceed Eligible Expenses or any specified limitation in the SPD.
- Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider's license.
- Counseling, education or training in the absence of illness.
    - Job help and outreach, social or fitness counseling:
        - Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff.
        - Private school or boarding school tuition.
- Any health examinations required:
    - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement; or
    - By any law of a government.
- Growth/Height: Any treatment, device, drug, service, or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Any hearing service or supply that does not meet professionally accepted standards.

- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device.
- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies including: 1) annual or other charges to be in a physician's practice; 2) Charges to have preferred access to a physician's services.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).
- Non-medically necessary services, including but not limited to, those treatments, services and supplies which are not medically necessary, as determined by the medical claims' administrator, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended, or approved by your physician or dentist.
- Over-the-counter hearing aids.
- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Sexual dysfunction/enhancement.
- Strength & Performance: Services, devices, and supplies to enhance strength, physical condition, endurance, or physical performance.
- Therapies and tests: Generally, any of the following treatments or procedures:
  - Aromatherapy;
  - Carbon dioxide therapy;
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
  - Massage therapy;
  - Megavitamin therapy;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Thermograms and thermography.
- Transplant: The transplant coverage does not include charges for:
  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services and supplies furnished to a donor when recipient is not a covered person;
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
  - Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing illness;

- Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by the medical claims administrator when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.
- Benefits are not provided for low-level laser therapy.
- Recreational, camp and activity-based programs. These programs are not medically necessary and include:
  - Gym, swim and other sports programs, camps and training;
  - Creative art, play and sensory movement and dance therapy;
  - Recreational programs and camps;
  - Hiking, tall ship, and other adventure programs and camps;
  - Boot camp programs and outward-bound programs;
  - Equine programs and other animal-assisted programs and camps; and
  - Exercise and maintenance-level programs.
- Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-Network providers may not bill members for these services and members are held harmless.
  - Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
  - Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.
  - Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed on your Premera Blue Cross ID card or on the Centers for Medicare and Medicaid Services (CMS) Web page at www.cms.hhs.gov.
- This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.
- This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
- Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous.
- Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Glossary. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
  - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
  - Medically Necessary.
  - Described as a Covered Health Service in this SPD under Additional Coverage Details and Plan Highlights.
  - Not otherwise excluded in this SPD under Exclusions and Limitations.
- Services or supplies if provision of the services or supplies are illegal under the applicable state law where the services or supplies are provided

CLAIMS PROCEDURES

When you receive in-network services, the Provider will generally collect your copayment from you at the time of your treatment and send a medical Claim to the Surest Plan for payment. Sometimes out-of-network Providers will do the same.

Other times, out-of-network Providers may bill you for the total cost of your treatment, and you will need to submit the medical Claim to the Surest Plan to be reviewed for Benefits. Whether you pay out-of-pocket, or your Provider bills the Surest Plan directly, you are still entitled to the same Benefits.

If you receive a bill from your Provider (whether in-network or out-of-network) for the Surest Plan's portion of the costs, or you pay for your medical care out-of-pocket and need to be reimbursed, you must submit a medical Claim to the Surest Plan. This section summarizes the procedures you must follow to submit a medical Claim for payment, and the procedures the Surest Plan will use to determine whether and how much to pay for that medical Claim.

If you would like more details about medical Claims procedures and your rights and responsibilities, contact Surest Member Services.

Regular Post-Service Medical Claims

Post-service medical Claims are non-urgent medical Claims processed after you have received treatment. Pre-Service and Urgent Care Request for Benefits are described in Section 8 (What Do I Do If My Claim Is Denied). Generally, you do not need to file a medical Claim for services from in-network Providers; the Provider will handle the filing of the medical Claim. For out-of-network Providers that do not file medical Claims or if you receive Emergency care outside the United States and are seeking reimbursement from the Surest Plan, you can submit a medical Claim using this procedure.

You can submit a post-service medical Claim by mail to the address on your member ID card. You will need to provide several pieces of information for Surest to be able to process your medical Claim and determine the appropriate Surest Plan Benefits:

- The name and birth date of the Participant who received the care.
- The Participant ID listed on the Surest member ID card.
- An itemized bill from your Provider, which should include:
  - The Provider's name, address, tax identification number, NPI number, and license number (if available).
  - The date(s) the Participant received care.
  - The diagnosis and procedure codes for each service provided.
  - The charges for each service provided.
- Information about any other health coverage the Participant has.
- Proof of payment may be requested to substantiate your medical Claim but is not required upon initial submission to Surest.

Other General Claims Procedures

Your medical Claim must be submitted within one year from the date you received the health care services. If you are not capable of submitting a Claim within one year, you must submit the Claim as soon as reasonably possible. If your Claim relates to an inpatient stay, the date you were discharged counts as the date you received the health care service for Claims purposes.

You will receive a decision within 30 days of submitting your Claim. If we need more information on a Claim, we will reach out to you to request that additional information, but we will still make a decision on your Claim within 30 days. If you submit the requested additional information after a decision has been made, we may adjust our decision and reprocess your Claim accordingly.

Claims for medical (non-pharmacy) Benefits will be reviewed by Surest. If more time is needed to decide your Claim, we may request a one-time extension of not more than 15 days.

If a Claim for a welfare benefit is denied or ignored, in whole or in part, a Participant has a right to know why this was done, to obtain copies of documents (without charge) relating to the decision, and to appeal any denial, all within certain time schedules.

Notice of Adverse Claim Determination

If your medical Claim is denied in whole or in part, you will receive a written notice of denial. The notice will be written in an understandable and, where required by law, in a culturally and linguistically appropriate manner and will include all of the following:

- Information sufficient to identify the medical Claim involved (including the date of service, the health care Provider, and the medical Claim amount [if applicable]); you can also request from the Claims Administrator the diagnosis and treatment codes, and their explanation.
- The specific reason or reasons for the denial, the denial code and its meaning and a description of the Plan standard, if any, that was used in denying the Claim and a discussion of the decision.
- The specific reference to the relevant Plan provision on which the decision is based.
- A description of additional information needed to support your medical Claim and an explanation of why it is needed.
- Information about how to appeal your Claim and any time limits, should you want to pursue it further and your right to bring a civil action under ERISA if your appeal is denied.
- A statement about available external review processes, including information on how to initiate the review.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either a copy of the document or a statement that such a document was relied on and that a copy will be provided (free of charge) upon request.
- Either an explanation of the scientific or clinical judgment for the decision (applying the Plan terms to your medical circumstances) or a statement that such an explanation was relied on and that a copy will be provided (free of charge) upon request, if the decision was based on a limit (for example, a decision that the proposed service is not Medically Necessary).
- A description of the expedited review process in the case of a denial concerning a Claim involving urgent care. If we tell you about our decision orally within the timeframes required, we will follow up within three business days with a written or electronic notice.
- A statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A description of any voluntary processes the Plan offers.

WHAT DO I DO IF MY CLAIM IS DENIED?

If Your Medical Claim is Denied

If a medical Claim for Benefits is denied in part or in whole, you are encouraged to call Surest Member Services before requesting a formal appeal. If Surest Member Services cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

To submit a medical Claim appeal:

1) Contact Surest Member Services to request a medical Appeal Filing Form or refer to the medical Appeal Filing Form included with your Explanation of Benefits.

2) Complete the medical Appeal Filing Form.

3) Submit the completed medical Appeal Filing Form along with your denial notice and any supporting documentation to:

   Surest
   Consumer Affairs (Member Appeals)

P.O. Box 31270
Salt Lake City, UT 84131

Review of a Medical Appeal

Surest will conduct a full and fair review of your medical Claim appeal.

You can send written comments, documents, records, and any other information you think will help decide the medical Claim appeal.

You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Participant's medical Claim for Benefits. "Relates to" means at least one of the following:

- That we used the information to make the Benefit determination.
- The information was submitted, used, or created while making the Benefit determination.
- The information shows that we made the Benefit determination based on your Plan documents and made the same decision for other Plan Participants in the same situation.
- The information is one of our policies or guidance.

When Surest reviews your medical Claim appeal, Surest will take into account all comments, documents, records, and other information you give, even if we did not have that information when we denied the medical Claim.

Surest adheres to the following review practices:

- The appeal will be reviewed by an appropriate individual(s) who did not make the initial Benefit determination and who does not report to the person who did make the initial Benefit determination.
- If your medical Claim involves medical judgment or whether the medical Claim is about investigational or Experimental services, the appeal will be reviewed by a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.
- Surest will review all medical Claims in accordance with the rules established by the U.S. Department of Labor and applicable state law.
- Our reviewers avoid conflicts of interest and act independently and impartially. We do not hire, pay, terminate, promote, make decisions, or incentivize medical Claims reviewers to make denials.

Once the review is complete, if Surest upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

If you are not satisfied with the first-level medical Claim appeal decision, you have the right to request a second-level medical Claim appeal within 60 days of receipt of the first-level medical Claim appeal determination.

Access to New or Additional Information

If you ask, we will give you the identification of any medical expert who gave an opinion – whether or not we used that opinion to decide your medical Claim. Any Participant will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required, with: (i) any new or additional evidence considered, relied upon, or generated by the Surest Plan in connection with the medical Claim; and (ii) a reasonable opportunity for any Participant to respond to such new evidence or rationale.

Pre-Service and Urgent Care Request for Benefits

A pre-service request for Benefits is a type of Benefit request that requires Prior Authorization but is not urgent. An urgent care request for Benefits is a special type of Prior Authorization that occurs when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. Because your Provider is the one who initiates Prior Authorization, it will usually be your Provider who will request expedited processing. An urgent care request for Benefits will be decided as soon as possible, taking into account the medical exigencies, but no more than 72 hours after we receive your request. Urgent care requests for Benefits filed improperly or missing information may be denied.

If your pre-service or urgent care request for Benefits is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request an expedited review).

Timing of Medical Claim Appeals Determinations

Separate schedules apply to the timing of Benefit requests and medical Claim appeals, depending on the type of request. There are four types of requests:

- **Urgent Care Request for Benefits:** A request for Benefits provided in connection with urgent care services.
- **Concurrent Care Requests:** A request to extend an already approved ongoing course of treatment that was approved for a specific period of time or a specific number of treatments. If the request is urgent, we will follow the urgent care request for Benefits and appeals process. If it is not urgent, it will be treated like a new request for services and will follow the Pre-Service Request for Benefits and Appeal process.
- **Pre-Service Request for Benefits:** A request for Benefits which the Surest Plan must approve or for which you must notify Surest before non-urgent care is provided.
- **Post-Service Medical Claim Request for Benefits:** A medical Claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Surest Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in a decision letter to you from Surest.

The tables below describe the time frames which you and Surest are required to follow.

Urgent Care Request for Medical Benefits and Appeal*

Request for Urgent Care or Concurrent Care Benefits	Claims Timing
If your request for medical Benefits is incomplete, Surest must notify you within:	**24 hours** and advise you what information is needed
You must then provide a completed request for medical Benefits to Surest within:	**48 hours** after receiving notice of additional information required
Surest must notify you of the medical Benefit determination within:	**48 hours** of receiving the needed information
If your request for medical Benefits is complete when it is filed, Surest must notify you within:	**72 hours**
If Surest denies your request for medical Benefits, you must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination
Expedited Appeals (Urgent Care or Concurrent Care)	**Appeals Timing**
Surest must notify you of the medical Claim appeal decision within:	**72 hours** after receiving the medical Claim appeal — if the medical Claim appeal is still urgent. If services have already been provided, we follow the Post-service medical Claim appeals process.

* *Follow the procedure for an Expedited Appeal provided in your denial of coverage letter.*

Pre-Service Request for Medical Benefits and Appeal*

Request for Pre-Service Benefits	Claims Timing
If your request for medical Benefits is filed improperly, Surest must notify you within:	**5 days**
If your request for medical Benefits is incomplete, Surest must notify you within:	**15 days**
You must then provide a completed request for medical Benefits information to Surest within:	**45 days**
Surest must notify you of the medical Benefit determination:	
■ If the initial request for medical Benefits is complete, within:	**15 days**
■ After receiving the completed request for medical Benefits (if the initial request for medical Benefits is incomplete), within:	**15 days***
* *Surest may require a one-time extension for the request for Pre-Service Benefits, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Surest Plan. Surest will notify you if Surest determines that the additional time is needed before the 15 days expires.*	
You must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination
Appeals (Pre-Service)	**Appeals Timing**
Surest must notify you of the first-level medical Claim appeal decision within:	**15 days** after receiving a complete first-level medical Claim appeal
You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within:	**60 days** after receiving the first-level medical Claim appeal decision
Surest must notify you of the second-level medical Claim appeal decision within:	**15 days** after receiving a complete second-level medical Claim appeal

Post-Service Medical Claim Request for Benefits and Appeal*

Post-Service Claim	Claims Timing
If your medical Claim is incomplete, Surest must notify you within:	**30 days**
You must then provide completed medical Claim information to Surest within:	**45 days**
Surest must notify you of the Benefit determination:	
■ If the initial medical Claim is complete, within:	**30 days**
■ After receiving the completed medical Claim (if the initial medical Claim is incomplete), within:	**30 days**
* *Surest may require a one-time extension for the initial Post-Service Claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Surest Plan. Surest will notify you if Surest determines that the additional time is needed before the 30 days expires.*	
You must appeal an Adverse Benefit Determination no later than:	**180 days** after receiving the Adverse Benefit Determination

Appeals (Post-Service)	Appeals Timing
Surest must notify you of the first-level medical Claim appeal decision within:	**30 days** after receiving the first-level medical Claim appeal
You must appeal the first-level medical Claim appeal (file a second-level medical Claim appeal) within:	**60 days** after receiving the first-level medical Claim appeal decision
Surest must notify you of the second-level medical Claim appeal decision within:	**30 days** after receiving the second-level medical Claim appeal

Concurrent Care Request for Benefits

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you may want to extend that course of treatment. This is called a Concurrent Care Claim.

If your extension request is not "urgent" (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent you may request expedited processing.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Surest will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If we inform you about our decision orally, we will follow up within three business days with a written or electronic notice.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Please note that the decision is based only on whether or not Benefits are available under the Surest Plan for the proposed treatment or procedure.

If your Concurrent Care Claim is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). You may have the right to an external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in decision letter to you from Surest.

Notice of Claim Denial on Appeal

If your Claim is denied on appeal, the reviewer will provide you with a notice of the Adverse Benefit Determination that will:

- Be written in a manner designed to be understood by an average individual and, where required by law, in a culturally and linguistically appropriate manner.
- Include information sufficient to identify the Claim involved (including the date of service, the health care Provider, and the Claim amount [if applicable]); you can also request from the reviewer the diagnosis and treatment codes and their explanation.
- Include the specific reasons for the Adverse Benefit Determination (including the denial code and its meaning and a description of the Plan's standard, if any, that was used in denying the Claim and a discussion of the decision).
- Refer to the specific Plan provisions on which the determination was based.
- Inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to the Claim for Benefits.
- Notify you of your right to bring legal action under ERISA.

- Include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such material is available (free of charge) upon request.
- Either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge, if the determination was based on Medical Necessity or similar exclusion or limit.
- Contain a statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A statement about any voluntary appeal procedures your Plan may offer.
- Notify you that you can contact the Department of Labor or State Insurance Regulatory Agency to learn about other voluntary alternative dispute resolution options.

The reviewer's decision on appeal is the final internal Adverse Benefit Determination.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Surest, you may be entitled to request an external review. The process is available at no charge to you.

You can also start the external review process without exhausting the internal appeals if Surest fails to follow the internal appeals process described above (unless it is a minor failure).

If one of the above conditions is met, you may request an external review of Adverse Benefit Determinations based upon any of the following:

- Medical judgement and/or Clinical reasons — for example Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered Benefit.
- A determination that a treatment, service, drug, or device is an Experimental or Investigational Service(s) or Unproven Service(s).
- Whether a Participant is entitled to a reasonable alternative standard for a reward under a wellness program.
- A determination as to whether a Plan is complying with non-quantitative mental health parity requirements.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, call Surest Member Services or by sending a written request to the address set out in the determination letter. A request must be made within 120 days after the date you received the final internal Adverse Benefit Determination letter from Surest.

An external review request should include all of the following:

- A specific request for an external review.
- The Participant's name, address, and member ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Surest has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available, and both are free to you.

Standard External Review

A standard external review comprises of all of the following:

- A preliminary review by Surest of the request completed within five business days following Surest's receipt of the request.
- A referral of the request by Surest to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, Surest will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following criteria:

- Is or was covered under the Surest Plan at the time the health care service or procedure that is at issue in the request was provided.
- The denial does not relate to your eligibility to participate in the Plan.
- Has exhausted the applicable internal appeals process or is deemed to have exhausted the internal appeals process.
- Has provided all the information and forms required for Surest to process the request.

After completing the preliminary review, Surest will issue a notification in writing to you within one business day. If the request is eligible for external review, Surest will assign an IRO to conduct such review. Surest will assign requests by either rotating assignments among the IROs or by using a random selection process.

If the request is complete but not eligible for external review, Surest will provide notification that includes the reasons for ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete; you will have at least 48 hours (or, if longer, until the end of the four-month filing period) to complete the request.

The IRO will timely notify you in writing whether the request is eligible for external review. Within 10-business days following the date of receipt of the notice, you may submit in writing to the IRO additional information for the IRO to consider in conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10-business days.

Surest will provide to the assigned IRO the documents and information considered in making the determination, including:

- All relevant medical records.
- All other documents relied upon by Surest.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and Surest will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Surest. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after receiving the request for the external review (unless they request additional time, and you agree). The IRO will deliver the notice of Final External Review Decision to you and Surest, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the determination made by Surest, the Surest Plan will immediately provide coverage or payment for the Benefit Claim at issue in accordance with the terms and conditions of the Surest Plan, and any applicable law regarding Plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Surest Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The time for completing the review process is much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An Adverse Benefit Determination of a Claim or appeal if the Adverse Benefit Determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure, or product for which the individual received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Surest will determine whether the individual meets both of the following criteria:

- Is or was covered under the Surest Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that Surest may process the request.

After completing the review, Surest will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Surest will assign an IRO in the same manner Surest utilizes to assign standard external reviews to IROs. Surest will provide all necessary documents and information considered in making the Adverse Benefit Determination or final Adverse Benefit Determination to the assigned IRO electronically, by telephone, facsimile, or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the Claim as new and not be bound by any decisions or conclusions reached by Surest. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice the assigned IRO will provide written confirmation of the decision to you and to Surest.

You may contact Surest Member Services for more information regarding external review rights, or if you are making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your Claim have been completed.

WHAT ELSE DO I NEED TO KNOW?

Subrogation, Overpayment and Reimbursement

Subrogation and Refund

A Participant may incur medical expenses due to illness or injuries that may be caused by the act or omission of a Third Party. Also, a Third Party (such as an insurance company) may be responsible for payment on account of the actions of another person or entity. In such circumstances, the Participant may have a claim against the Third Party for payment of medical expenses. Accepting Benefits under the Plan/Surest Plan for those incurred medical expenses automatically assigns to the Plan/Surest Plan any rights the Participant may have to Recoveries from any Third Party up to the full amount of such Benefits. This Subrogation right allows the Plan/Surest Plan to pursue any claim that the Participant has against any Third Party, whether or not the Participant chooses to pursue that claim. The Plan/Surest Plan may make a claim directly against the Third Party, but in any event, the Plan/Surest Plan has an equitable lien on any amount of the Recovery of the Participant whether or not designated as payment for medical expenses. In addition, each Participant agrees to hold Recoveries in a constructive trust for the benefit of the Plan/Surest Plan. The equitable lien and constructive trust shall remain in effect until the Plan/Surest Plan is repaid in full. In the event that the Participant(s) dies as a result of their injuries and a wrongful death or survivor claim is asserted against a Third Party, the Plan's/Surest Plan's Subrogation and Refund rights shall still apply.

Assignment of Interest and the Plan's/Surest Plan's Recovery Right

The Participant:

- Automatically assigns to the Plan/Surest Plan their rights against any Third Party when this provision applies.
- Must repay to the Plan/Surest Plan the Benefits paid on their behalf out of any Recovery.

Each Participant is individually obligated to comply with the provisions of this section. When a Participant receives or claims Plan/Surest Plan Benefits for an illness or injury caused by another, the Participant agrees to immediately reimburse the Plan/Surest Plan from any Recovery for Benefits paid out by the Plan/Surest Plan.

Make Whole and Common Fund Doctrines Inapplicable

The Plan/Surest Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan/Surest Plan from receiving a Recovery unless a Participant has been "made whole" with regard to illness or injury that is the responsibility of a Third Party. The Plan/Surest Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan/Surest Plan to pay a portion of the attorney fees and costs expended in obtaining a Recovery. These doctrines have no application to the Plan/Surest Plan since the Plan's/Surest Plan's Refund rights apply to the first dollars payable by a Third Party.

Duty to Cooperate

Participants are required to cooperate with the Plan Administrator to effectuate the terms of this section. Specifically, it is the Participant's obligation at all times, both prior to and after payment of medical Benefits by the Plan/Surest Plan:

- To cooperate with the Plan/Surest Plan, or any representatives of the Plan/Surest Plan, in protecting the Plan's/Surest Plan's rights, including discovery, attending depositions, and/or cooperating at trial.
- Provide prompt notice to the Plan/Surest Plan when a claim is made against a party for illness or injury.
- To provide the Plan/Surest Plan with pertinent information regarding the illness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information.
- To take such action and execute such documents as the Plan/Surest Plan may require to facilitate enforcement of its Subrogation and reimbursement rights.
- To do nothing to prejudice the Plan's/Surest Plan's rights of Subrogation and Refund.
- To promptly reimburse the Plan/Surest Plan when a Recovery through settlement, judgment, award, or other payment is received.
- To not settle or release, without the prior consent of the Plan/Surest Plan, any claim to the extent that the Participant may have Recovery rights against any Third Party.

If the Participant and/or their attorney fails to reimburse the Plan/Surest Plan for all Benefits paid or to be paid from any Recovery, the Participant will be responsible for any and all expenses (including attorney fees and costs) associated with the Plan's/Surest Plan's attempt to Recover such money from the Participant or a Third Party.

Conditions Precedent to Coverage

The Plan/Surest Plan shall have no obligation whatsoever to pay medical Benefits to a Participant if a Participant refuses to cooperate with the Plan's/Surest Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as the Plan/Surest Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Participant is a minor, the Plan/Surest Plan shall have no obligation to pay any medical Benefits incurred on account of illness or injury caused by a Third Party until after the Participant or his or her authorized legal representative obtains valid court recognition and approval of the Plan's/Surest Plan's 100%, first-dollar Subrogation and Refund rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Other Coverage

When medical payments are available under other coverage, the Plan/Surest Plan shall always be considered secondary to such plans and/or policies. Other coverage shall include, but is not limited to:

- Any primary payer besides the Plan/Surest Plan.
- Any other group health plan.
- Any other coverage or policy covering the Participant.
- Any first-party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a responsible party.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source Including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Offset

Failure by a Participant and/or his/her attorney to comply with any of the requirements described in this section may, at the Plan's/Surest Plan's discretion, result in a forfeiture of payment by the Plan/Surest Plan of future medical Benefits, and any funds or Benefits otherwise payable under the Plan/Surest Plan to or on behalf of the Participant may be withheld until the Participant satisfies his or her obligation.

Defined Terms

The following terms have special meanings for purposes of this section:

- **"Recover," "Recovered," "Recovery" or "Recoveries"** means all monies paid by a Third Party to, or on behalf of, a Participant by way of judgment, settlement, or otherwise to compensate for all losses caused by an illness or injury, whether or not said monies are characterized as medical expenses covered by the Plan/Surest Plan. "Recoveries" includes, but is not limited to, Recoveries for medical expenses, attorney's fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages, and any other Recovery of any form of damages or compensation whatsoever.
- **"Refund"** means repayment to the Plan/Surest Plan for medical Benefits that the Plan/Surest Plan has paid toward care and treatment of an illness or injury suffered by a Participant as the result of acts or omissions of a Third Party. This right of Refund includes Recoveries by a Participant under an uninsured or underinsured motorist insurance policy, homeowner's policy, renter's policy, medical malpractice policy, or any liability insurance policy (each of which will be treated as Third Party coverage under this article).
- **"Subrogation"** means the Plan's/Surest Plan's right to pursue and place a lien upon the Participant's claims for medical expenses against the other person.
- **"Third Party"** means any individual or entity (including an insurance company) who is legally obligated to pay a Recovery to, or on behalf of, a Participant.

Erroneous Payments

To the extent payments made by the Plan/Surest Plan with respect to a Participant are in excess of the maximum amount of payment necessary under the terms of the Plan/Surest Plan, the Plan/Surest Plan shall have the right to Recover such payments, to the extent of such excess from any one or more of the following sources, as the Plan/Surest Plan shall determine any person to or with respect to whom such payments are made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan/Surest Plan determines are either responsible for payment or received payment in error, and any future Benefits payable to the Participant.

Excess Insurance

Except as otherwise provided under Section 11.2 (Coordination of Benefits) the following rule applies:

- If there is available, or potentially available, any coverage (including coverage resulting from a judgment at law or settlements), the Benefits under the Plan/Surest Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under Section 11.2 (Coordination of Benefits).
- The Plan's/Surest Plan's Benefits shall be excess to:
  - The responsible party, its insurer, or any other sources on behalf of that party.
  - Any first party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage.
  - Any policy of insurance from any insurance company or guarantor of a Third Party.
  - Worker's compensation or other liability insurance company.
  - Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan/Surest Plan, funds Recovered by the Participant(s), and funds held in trust over which the Plan/Surest Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s) or filing of bankruptcy by the Participant(s), will not affect the Plan's/Surest Plan's equitable lien, the funds over which the Plan/Surest Plan has a lien, or the Plan's/Surest Plan's right to Subrogation and reimbursement.

Severability

In the event that any provision of this section is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this section and the Plan/Surest Plan. The provision shall be fully severable. The Plan/Surest Plan shall be construed, and provisions enforced as if such invalid or illegal provision had never been inserted in the Plan/Surest Plan.

Plan Administrator's Responsibilities

T-Mobile USA, Inc. is the Plan Sponsor and Plan Administrator of this Benefit Plan.

The Plan Administrator has the authority and discretion to interpret the Plan's terms and Benefits available under the Plan and to make factual and legal decisions about them. The Plan Administrator has powers and duties of the general administration of this Plan, including the following:

- To administer the Plan in accordance with its terms.
- Interpret this SPD.
- Develop policies, practices, and procedures for this Plan.
- Administer the Plan in accordance with those policies, practices, and procedures.

The Plan Administrator will exercise its discretion and fulfill its responsibilities in accordance with the provisions of ERISA. The Plan Administrator may delegate some of its responsibilities to Surest or to the individuals or entities as appropriate. Surest may make fiduciary decisions in its role as Claims Administrator. It may also make ministerial and non-fiduciary decisions to facilitate Plan administration, including but not limited to, developing, interpreting, and relying upon policies, practices, and procedures for the administration of the Surest Plan, but is not financially responsible for Claims.

The Plan Administrator serves without compensation.

Other Information About Your Surest Plan

Conformity with Applicable Laws

It is intended that the Plan will conform to the requirements of any applicable federal, state, or local law, regulation, guidance, or the order or judgement of a court of competent jurisdiction, and this Plan will be deemed automatically amended to conform, including without limitation, in the event any law, regulation, guidance, or the order or judgement of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be deemed to be in accordance with the terms of the Plan.

Non-Discrimination Policy

This Plan will not discriminate against any Participant based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This Plan will not establish rules for eligibility based on health status, medical condition, Claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

This Plan intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986 (Code). If the Plan Administrator determines before or during any Plan Year that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on Benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to ensure compliance with such requirements or limitation.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care Benefits and covered mental health and substance disorder Benefits relating to financial cost-sharing restrictions and treatment-duration limitations. For further details, please contact the Plan Administrator.

Newborns' and Mothers' Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Surest Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order Procedures

The Surest Plan will provide Benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA Section 609(a) or National Medical Support Notice. If the Surest Plan receives a medical child support order for your child that instructs the Surest Plan to cover the child, the Plan Administrator will review it to determine that it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Surest Plan as your dependent, and the Surest Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

Your Surest Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides Benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information. GINA expands on the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in a number of ways:

- Group health plans and health insurers cannot base health care premiums for plans or a group of similarly situated individuals on genetic information.
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test.
- Plans and insurers are prohibited from collecting genetic information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

Patient Protection Notice

T-Mobile USA, Inc.: Surest Plan generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at Benefits.Surest.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

GLOSSARY

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Surest Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Surest Plan.

Adverse Benefit Determination	An Adverse Benefit Determination is a denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity.
Ancillary Services	Items and services provided by out-of-network Physicians at a Network facility that are any of the following: ■ Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; ■ Provided by assistant surgeons, hospitalists, and intensivists; ■ Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary; ■ Provided by such other specialty practitioners as determined by the Secretary; and ■ Provided by an out-of-network Physician when no other Network Physician is available.
Authorized Representative	A person you appoint to assist you in submitting a Claim or appealing a Claim denial. You will be required to designate your Authorized Representative in writing. This could also be a Provider for urgent care Claims and expedited appeals. The appointment of an Authorized Representative is revocable by you.
Autism Spectrum Disorder	A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early development period that cause clinically significant impairment in social, occupational, or other important areas of functioning and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
Benefits	Plan payments for Covered Health Services, subject to the terms and conditions of the Plan as explained in this SPD and any addendums or amendments.
Claim	A request for Benefits made by a Participant or his/her Authorized Representative in accordance with the procedures described in this SPD. It includes Prior Authorization requests; pre-service request for Benefits and appeals; urgent care request for Benefits and appeals; concurrent care request for Benefits and appeals; and post-services Claims.
Claims Administrator	Provides certain claim administration and other services for the Plan.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time. A federal law that requires employers to offer continued health insurance coverage to certain Employees/Retirees and their covered dependents whose group health insurance has been terminated.
Continuity of Care	The option for existing Participants to request continued care from their current health care professional if they are no longer working with their health plan and is now considered out-of-network.
Cosmetic	Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not Medically Necessary.

Covered Health Service	Health care services, including supplies or pharmaceutical products, which are determined to be all of the following: ■ Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms. ■ Medically Necessary. ■ Described as a Covered Health Service in this SPD. ■ Not excluded in this SPD.
Custodial Care	Services that are any of the following non-skilled care services: ■ Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating. ■ Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.
Designated Provider	A provider and/or facility that: ■ Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Service for the treatment of specific diseases or conditions; or ■ The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures. A Designated Provider may or may not be located within your geographic area. Not all network hospitals or network physicians are Designated Providers.
Designated Virtual Network Provider	A provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Services through live audio with video technology or audio only, and/or through federally compliant secure messaging applications.
Domiciliary Care	Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.
Durable Medical Equipment (DME)	Medical equipment that is all of the following: ■ Ordered or provided by a Physician for outpatient use primarily in a home setting. ■ Used for medical purposes. ■ Not consumable or disposable except as needed for the effective use of covered DME. ■ Not of use to a person in the absence of a disease or disability. ■ Serves a medical purpose for the treatment of a sickness or injury. ■ Primarily used within the home.
Effective Date	The first day of the Plan Year if you have timely completed all applicable enrollment requirements.
Eligible Charge	A charge for health care services, subject to all of the terms, conditions, limitations, and exclusions for which the Surest Plan, or Participant will pay.

Eligible Expenses	Charges for Covered Health Services that are provided while the Surest Plan is in effect and determined by the Claims Administrator. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies: ■ As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS). ■ As indicated in the most recent editions of the Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) Codes. ■ As reported by generally recognized professionals or publications. ■ As used for Medicare. ■ As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts. Network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. ***NOTE:*** *Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described above, except as required under the No Surprises Act, which is a part of the Consolidated Appropriations Act of 2021.*
Emergency	The sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in: ■ Placing the health of the Participant(or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ■ Serious impairment to bodily functions. ■ Serious dysfunction of any bodily organ or part.

Emergency Health Care Services	With respect to an Emergency: ■ An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and ■ Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)). ■ Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation or an inpatient stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met: ■ The attending Emergency Physician or treating Provider or facility, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition. ■ The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. ■ The patient is in such a condition to receive information as stated in b above and to provide informed consent in accordance with applicable law. ■ The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law. ■ Any other conditions as specified by the Secretary. The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.
ERISA	The Employee Retirement Income Security Act of 1974 as amended from time to time. The federal law that regulates retirement and employee welfare benefit plans maintained by employers.
E-Visit and Telephone Consult with Your Physician	Services provided by a Physician performed without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal messages.

Experimental / Investigational Service(s)	A procedure, study, test, drug, equipment, or supply will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met: ■ It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose, or effectiveness in comparison to conventional treatments. ■ It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS). ■ Other facilities/Providers/etc. studying substantially the same drug, device, medical treatment, or procedure refer to it as Experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect. ■ The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings. ■ It is not Experimental or Investigational itself pursuant to the above criteria but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy). ■ It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use. ■ It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA. ■ It is the subject of an ongoing Clinical Trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS). ■ It is being used for off-label therapies for a non-indicated condition – even if FDA approve for another condition.
Explanation of Benefits (EOB)	The EOB provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Participant's responsibility. The EOB is not a bill, it is a statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains the Benefits provided (if any); the allowable reimbursement amounts; copayments; any other reductions taken; the net amount paid by the Surest Plan; and the reason(s) why the service or supply was not covered by the Surest Plan.
Independent Freestanding Emergency Department	A health care facility that: ■ Is geographically separate and distinct and licensed separately from a hospital under applicable state law; and ■ Provides Emergency Health Care services

Medically Necessary / Medical Necessity	Health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee. ■ In accordance with Generally Accepted Standards of Medical Practice. ■ Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your sickness, injury, mental illness, substance-related and addictive disorders, disease or its symptoms. ■ Not mainly for your convenience or that of your doctor or other health care provider. ■ Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms. *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator. The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Participants, Physicians and other health care professionals on Benefits.Surest.com. Participants may also call the telephone number on your ID card.
Network Pharmacy or Network Pharmacies	A retail or mail order pharmacy that has: ■ Entered into an agreement with an organization contracting on its behalf to dispense prescription drugs to Participants. ■ Agreed to accept specified reimbursement rates for dispensing prescription drugs. ■ Been designated by the Plan Administrator as a Network Pharmacy.
Observation Stay	Observation care consists of evaluation, treatment, and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital.
Open Enrollment	A period of time where eligible persons are able to enroll, disenroll, and make Surest Plan changes without a life status change or Adverse Health Factor.
Participant	The eligible employee or dependent properly enrolled in the Surest Plan under the eligibility rules and only while such person(s) is enrolled and eligible for Benefits under the Surest Plan.
Pharmacy Benefit Manager (PBM)	A third-party administrator of prescription drug programs for commercial health plans and self-insured employer plans.
Pharmacy Claims Administrator	Also known as the Pharmacy Benefit Manager, or PBM, which provides administrative services for the Plan Administrator in connection with the operation of the pharmacy plan, including processing of Claims, as may be delegated to it.

Physician	Any *Doctor of Medicine or Doctor of Osteopathy* who is properly licensed and qualified by law. ***NOTE:*** *Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of their license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a Provider as a Physician does not mean that Benefits for services from that Provider are available to you under the Surest Plan.*
Plan	T-Mobile USA, Inc.: Surest Plan.
Plan Administrator	The person or entity, as defined under Section (3)(16) of ERISA, that has the exclusive, final, and binding discretionary authority to administer the Surest Plan, to make factual determinations, to construe and interpret the terms of the SPD, the Surest Plan, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of Benefits. The Plan Administrator may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing Claims and performing other Surest Plan-connected administrative services.
Plan Sponsor	The entity that establishes and maintains the Surest Plan, has the authority to amend and/or terminate the Surest Plan and is responsible for providing funds for the payment of Benefits.
Plan Year	The period following the Effective Date of the Surest Plan and each subsequent period (generally 12 months) the Surest Plan remains in force.
Pre-Admission Notification	Process whereby the Provider or you inform the Surest Plan that you will be admitted to the inpatient hospital, Skilled Nursing Facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization, or Residential Treatment Facility. This notice is required in advance of being admitted for inpatient care for any type of non-Emergency admission and for partial hospitalization. All contracted facilities are required to provide Pre-Admission Notification to you.
Prior Authorization	Pre-service, urgent care request, concurrent care benefit coverage decision for a service, procedure, or test that has been subject to an evidence-based review resulting in a Medical Necessity determination.
Private Duty Nursing	Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or an office/home setting when any of the following are true: ▪ Services exceed the scope of intermittent care in the home. ▪ Skilled nursing resources are available in the facility. ▪ The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose. ▪ The service is provided to a Participant by an independent nurse who is hired directly by the Participant or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.
Provider	A health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term "Provider" refers to an in-network Provider unless otherwise specified.

Recognized Amount	The amount which the copayment is based on for the below Covered Health Services when provided by out-of-network Providers: ■ Out-of-network Emergency Health Care Services. ■ Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of *section 2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center described in *section 1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary. The amount is based on one of the following in the order listed below as applicable: 1) An All Payer Model Agreement if adopted; 2) Applicable state law; or 3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility. The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider. ***NOTE:*** *Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.*
Reconstructive	Surgery or procedure to restore or correct: ■ A defective body part when such defect is incidental to or follows surgery resulting from illness, injury, or other diseases of the involved body part. ■ A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician. ■ A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the Claim Administrator to be Medically Necessary.

Residential Treatment	Treatment in a facility which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services treatment. The facility must meet all of the following requirements: ■ It is established and operated in accordance with applicable state law for Residential Treatment programs. ■ It provides a program of treatment under the active participation and direction of a Physician. ■ It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services: ■ Room and board. ■ Evaluation and diagnosis. ■ Counseling. ■ Referral and orientation to specialized community resources. A Residential Treatment facility that qualifies as a hospital is considered a hospital.
Residential Treatment Facility	A facility that is licensed by the appropriate state agency, has, or maintains a written, specific, and detailed treatment program requiring full-time residence and participation, and provides 24-hour-a-day care in a structured setting, supervision, food, lodging, rehabilitation, or treatment for an illness related to mental health and substance use related disorders.
Secretary	As that term applied in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*. This definition encompasses the secretary of HHS, DOL and Treasury.
Shared Savings Program	A program in which the network partner may obtain a discount to an out-of-network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-network Provider. When this happens, you may experience lower out-of-pocket amounts. Surest Plan out-of-network copayments would still apply to the reduced charge. Sometimes the Surest Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the network partner, such as: ■ A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services* (CMS) for the same or similar service within the geographic market. ■ An amount determined based on available data resources of competitive fees in that geographic area. ■ A fee schedule established by a third-party vendor. ■ A negotiated rate with the Provider. In this case the out-of-network Provider may bill you for the difference between the billed amount and the rate determined by the network partner. If this happens you should call the number on your medical member ID Card. Shared Savings Program Providers are not network Providers and are not credentialed by the network partner.
Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law. Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care.
Specialist	A Physician who has a majority of their practice in areas other than those practicing in the areas of family practice, general medicine, internal medicine, obstetrics/gynecology or general pediatrics.

Specialty Drugs	Infusions, injectables and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics: ■ Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes. ■ Intensive patient training and compliance assistance are required to facilitate therapeutic goals. ■ There is limited or exclusive product availability and/or distribution. ■ There are specialized product handling and/or administration requirements. ■ Are produced by living organisms or their products.
Summary Plan Description (SPD)	The document describing, among other things, the Benefits offered under the T-Mobile USA, Inc.: Surest Plan and your rights and obligations under such benefit option as required by ERISA.
Surest Plan	Refers to the Surest health plan as used in this SPD.
Telehealth Visit	Live interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Participant's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.
Transition of Care	The option for a new Participant to request coverage from your current, out-of-network health care professional at in-network rates for a limited time due to a specific medical condition, until the safe transfer to an in-network health care professional can be arranged.
Unproven / Unproven Services	Services, including medications and devices regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature: ■ Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.) ■ Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.) Surest has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time Surest issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can contact Surest Member Services for additional information. ***NOTE:*** *If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), Surest may, at its discretion, consider an otherwise Unproven service to be a Covered Health Service for that sickness or condition. Prior to such a consideration, Surest must first establish that there is sufficient evidence to conclude that, even though Unproven, the service has significant potential as an effective treatment for that sickness or condition.*

Usual and Customary	The amount allowed for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The usual and customary amount is used to determine the amount that may be charged by a Provider for the Benefits.
Utilization Management	Utilization Management processes are conducted by Surest to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review (review of Claims to ensure services were Medically Necessary).
Virtual Care	Virtual care is for Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).

Premera Blue Cross (Premera) Medical Plans

CONTACTING PREMERA

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Premera, you may contact Premera in writing at:

Premera Blue Cross
7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

You may also use Premera's toll-free Medical customer service phone number on your Premera ID card or visit Premera's website at www.premera.com/T-Mobile.

EPO (YOUR FOCUS) OVERVIEW

First, here is a quick look at how this plan works. Your costs are subject to all of the following:

- **Networks.** To help control the cost of your care, this plan uses Premera's Heritage network in Washington. **You will need to use in-network providers in order for most of your care to be covered.** Emergency care is one exception. See the summary table for more exceptions. For more network details, see ***How Providers Affect Your Costs***.
- **Allowed amount.** This is the most this plan allows for a covered service. It is often lower than the provider's billed charge. Providers not in one of the plan's networks have the right to bill you for amounts over the allowed amount. See ***Important Plan Information*** for details. For some covered services, you have to pay part of the allowed amount. This is called your **cost share**. This plan's cost shares are explained below. You will find the amounts in the summary table.
- **Copays.** These are set dollar amounts you pay at the time you get some services. If the amount billed is less than the copay, you pay only the amount billed. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary table. The deductible does not apply to most services that require a copay. Any exceptions are shown in the Medical Benefits Summary table.
  - This plan has a different copay for office visits with specialists than with non-specialists. To find out which providers get which copays, see ***How Providers Affect Your Costs***.
- **Deductible.** The total allowed amount you pay in each year before this plan starts to make payments for your covered healthcare costs. You pay down the deductible with each claim.
- **Coinsurance.** For some healthcare, you pay a percentage of the allowed amount, and the plan pays the rest. This Summary Plan Document calls your percentage "coinsurance." Your coinsurance is shown in the Medical Benefits Summary.
- **Out-of-pocket maximum.** This is the most you pay each calendar year for any deductibles, copays, and coinsurance. Not all the amounts you have to pay count toward the out-of-pocket maximum. See ***Important Plan Information*** for details.
- **Prior authorization.** Some services must be approved in advance before you get them, in order to be covered. See Prior authorization for details about the types of services and time limits. Some services have special rules.

HOW YOUR EPO (YOUR FOCUS) PLAN WORKS

How Providers Affect Your Costs

This plan's benefits and your out-of-pocket expenses depend on the providers you see. In this section you'll find out how the providers you see can affect this plan's benefits and your costs.

This plan does not require use or selection of a primary care provider or require referrals for specialty care. Members may self-refer to in-network providers, including obstetricians, gynecologists, and pediatricians, to receive care, and may do so without prior authorization.

In-Network Providers

This plan is an Exclusive Provider Plan (EPO). This means that the plan is designed only to cover care delivered by providers in your plan's network. There are some exceptions, which are explained below.

In-network providers are:

- Providers in the Heritage network in Washington. For care in Clark County, Washington, you also have access to providers through the BlueCard® Program.
- Providers in Alaska that have signed contracts with Premera Blue Cross Blue Shield of Alaska.
- For care outside the service area (see ***Definitions***), providers in the local Blue Cross and/or Blue Shield Licensee's network shown below. (These Licensees are called "Host Blues" in this Summary Plan Document.) See ***Out-Of-Area Care*** later in the Summary Plan Document for more details.
  - Wyoming: The Host Blue's Traditional (Participating) network.
  - All Other States: The Host Blue's PPO (Preferred) network.

In-network providers provide medical care to members at negotiated fees. These fees are the allowed amounts for in-network providers. In-network providers will not charge you more than the allowed amount for covered services. This means that your portion of the charges for covered services will be lower.

A list of in-network providers is in our Heritage provider directory. You can access the directory at any time on our Web site at www.premera.com/T-Mobile. You may also ask for a copy of the directory by calling customer service. The providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. You can also call the BlueCard provider line to locate an in-network provider. The numbers are on your Premera ID card.

We update this directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location, or their provider group is in the Heritage network.

IMPORTANT NOTE: *You're entitled to receive a provider directory automatically, without charge.*

Contracted Health Care Benefit Managers

The list of Premera's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at https://www.premera.com/visitor/partners-vendors and changes to these contracts or services are reflected on the website within 30 business days.

Continuity Of Care

How Continuity of Care Works. You may qualify for Continuity of Care (COC) under certain circumstances when a provider leaves your health plan's network or your employer transitions to a new carrier. This will depend on your medical condition at the time the change occurs. COC is a process that provides you with short-term, temporary coverage at in-network levels for care received by a non-participating provider.

COC applies in these situations:

- The contract with your provider ends
- The benefits covered for your provider change in a way that results in a loss of coverage
- The contract between your company and us ends and that results in a loss of benefits for your provider

How you qualify for Continuity of Care. If a professional provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination. During this time, Premera will consider the professional provider to still have an agreement only while this policy remains in effect and for the period that is the longest of the following:

- The end of the current policy year
- Until the end of the next open enrollment period, as required under state law
- -Up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment
- Through completion of postpartum care, if the member is pregnant on the date of termination; or
- Until the end of the medically necessary treatment for the medical condition if the member has a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year.

We will notify you at least 30 days prior to your provider's termination date. When a termination for cause provides us less than 30 days' notice, we will make a good faith effort to assure that a written notice is provided to you immediately.

You can request continuity of care by contacting customer service. The contact information is on the back cover of this booklet.

If you are approved for continuity of care, you will get continuing care from the terminating provider until the earliest of the following:

- The 90th day after we notified you that your provider's contract ended
- The day after you complete the active course of treatment entitling you to continuity of care
- If you are pregnant, and become eligible for continuity of care, you can continue with your provider throughout your pregnancy, plus 8 weeks of postpartum care.

Continuity of care does not apply if your provider:

- No longer holds an active license
- Relocates out of the service area
- Goes on leave of absence
- Is unable to provide continuity of care because of other reasons
- Does not meet standards of quality of care

When continuity of care ends, non-emergent care from the provider is no longer covered. If we deny your request for continuity of care, you may appeal the denial. See ***Complaints and Appeals***.

Levels of Care

Healthcare is delivered in many settings with distinct levels of care. Each level of care involves a different intensity of service to treat your medical and behavioral health symptoms. Premera covers the least intensive level of care that is medically necessary to treat your symptoms. Care is often provided in a continuum beginning with acute care and transitioning to outpatient care as symptoms or condition improve. Please see Premera medical policies for Medical Necessity criteria for each type of care.

Acute Inpatient Level of Care

- Medical, surgical or behavioral health hospitals (see ***Definitions*** for Hospital or Inpatient)

Acute facilities provide treatment for severe episodes of Illness, Injury, or behavioral health symptoms, and for recovery from surgery. You are monitored for medical, surgical and psychiatric symptoms, with 24-hour availability of appropriate medical and psychiatric practitioners, and 24/7 onsite nursing services. Care may begin in the emergency room or an outpatient medical, surgical, or behavioral health setting with transition to an acute inpatient level of care to address your needs. Specialty-appropriate physicians, nurse practitioners, or physician assistants perform physical examinations or psychiatric evaluations within one day of hospital admission. Hospitals provide daily physical examination or psychiatric evaluation, daily nursing observation, and daily treatment during the stay. A plan for treatment and transition to lower levels of care is established shortly after admission. A brief hospital stay while on Observation is considered to be Outpatient care.

Acute care facilities are licensed by the applicable state health department as a hospital or as a behavioral health evaluation and treatment facility.

Intermediate Level Facilities

- Long-term Acute Care Hospitals (LTAC or LTACH)
- Inpatient Rehabilitation Hospitals or Units
- Skilled Nursing Facilities (see ***Definitions*** for Skilled Nursing Facility and Skilled Nursing Care)
- Residential Treatment Programs in residential treatment facilities or wilderness settings

Intermediate care facilities are a bridge between acute and outpatient care settings. They serve those who do not require the intensity of service that acute hospitals provide but are not yet ready to step-down to outpatient care. Their purpose is to improve function and stabilize you for transition to outpatient services. Intermediate level facilities provide care for patients' medical needs as well as daily living support. Patients typically reside in the facility for the duration of their treatment.

Intermediate level care may be provided in a free-standing facility or in a segregated location within another facility. Wilderness programs providing behavioral health care in an outdoor setting and with the structure and intensity of a residential treatment program are also intermediate level care. Inpatient Hospice and facilities providing Custodial Care are not intermediate level facilities.

Intermediate care facilities are licensed by the applicable state health department as a healthcare or behavioral health facility. A program operating under another type of state licensure, such as a child-care license, is not an intermediate facility. Intermediate care facilities have the following characteristics:

- Onsite nursing at all times (or, for behavioral health programs, on-call nursing and onsite mental health practitioner)
- Admission evaluation or psychiatric assessment by an appropriately licensed provider by at least shortly after admission and at least weekly (every seven days) thereafter
- Daily treatment by appropriate licensed clinical providers
- A plan for treatment established shortly after admission
- Discharge planning for transition to lower levels of care

Please see Premera medical policies for Medical Necessity criteria for each type of care.

Intermediate Level Ambulatory or Outpatient Care

- Partial Hospitalization Programs for Psychiatric or Substance Use Disorder Treatment
- Intensive Outpatient Psychiatric or Substance Use Disorder Treatment Programs
- Home Health Care
- Residential Neurological Rehabilitation or Rehab Without Walls

Intermediate level outpatient programs provide intensive services to those who can function safely in a community-based setting but require a higher level of care than is provided in an outpatient office visit. Intermediate level outpatient programs may be provided by inpatient or intermediate level facilities however patients typically reside at their own homes and visit the facilities for treatment only. Some may offer programs where you can pay to reside within the facility while an outpatient level of care is provided when facility is away from your home.

Outpatient Care

- Hospital Observation
- Hospital Emergency Department
- Ambulatory Surgical Center or Outpatient Surgical Center
- Ambulatory or Outpatient Rehabilitation
- Urgent Care
- Office Visits
- Virtual Care

Outpatient care may be provided in hospital, surgical center, clinic, or office settings, or remotely through virtual care. Outpatient services are unstructured and provide maximum freedom.

Non-Participating Providers

Non-participating providers are either (1) providers that are not in one of the networks (Out-Of-Network) shown above or (2) providers that do not have a contract with us (Non-Contracted). Except as stated in ***Benefits For Out-Of-Network Or Non-Contracted Providers***, or in a few specific benefits, services from these providers are not covered.

- Some providers in Washington have a contract with but are not in the Heritage network. In cases where this plan covers services from these providers, they will not bill you for any amount above the allowed amount for a covered service. The same is true for a provider that is in a different network of the local Host Blue plan.
- There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers are called "non-contracted" providers in this booklet. When covered, benefits for their covered services are based on a lower allowed amount. See ***Important Plan Information***. "Non-contracted" providers have the right to charge you more than the allowed amount for a covered service. You may also be required to submit the claim yourself. See ***How Do I File A Claim?*** for details.

Amounts in excess of the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Services you receive in an in-network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are out-of-network providers. In cases where these out-of-network providers are covered, you may be responsible for amounts over the allowed amount, as explained above.

Balance Billing Protection

Non-participating providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, federal law protects you from balance billing for:

Emergency Services from a nonparticipating hospital or facility or from a nonparticipating provider at the hospital or facility.

Emergency services includes certain post-stabilization services you may get after you are in stable condition. These include covered services provided as part of outpatient observation or during an inpatient or outpatient stay related to the emergency visit, regardless of which department of the hospital you are in.

Non-emergency services from a **nonparticipating provider** at an **in-network hospital or outpatient surgery center.** If a non-emergency service is not covered under the in-network benefits and terms of coverage under your health plan, then the federal and state law regarding balance billing do not apply for these services.

Air Ambulance

Your cost sharing for non-participating air ambulance services shall be no more than if the services were provided by an in-network provider. The cost sharing amount shall be counted towards the in-network deductible and the in-network out of pocket maximum amount. Cost sharing shall be based upon the lesser of the qualifying payment amount (as defined under federal law) or the billed amount.

For the above services, you will pay no more than the plan's in-network cost shares. See the ***Summary of Your Costs***. Premera Blue Cross will work with the nonparticipating provider to resolve any issues about the amount paid. Premera will also send the plan's payments to the provider directly.

NOTE: *Amounts you pay over the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.*

Benefits For Out-Of-Network Or Non-Contracted Providers

The following covered services and supplies provided by out-of-network or non-contracted providers will always be covered:

- Emergency services for an emergency medical condition. (See ***Definitions*** for definitions of these terms.) This plan provides worldwide coverage for emergency services.

The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services has a contract with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.

- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Facility and hospital-based provider services received from a hospital that has a provider contract with Premera Blue Cross.
- Covered emergency services received from providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network or non-contracted provider. However, you or your out-of-network provider must request this before you get the care. See ***Prior Authorization*** to find out how to do this.

IMPORTANT NOTE

YOU WILL RECEIVE AN **ID CARD**. IT IDENTIFIES YOU AS A MEMBER WHEN YOU RECEIVE SERVICES FROM HEALTH CARE PROVIDERS. IF YOU HAVE NOT RECEIVED YOUR PREMERA ID CARD OR IF YOUR CARD IS LOST OR STOLEN, NOTIFY PREMERA IMMEDIATELY AND A NEW CARD WILL BE ISSUED.

IMPORTANT PLAN INFORMATION

This section of your Summary Plan Document explains the types of expenses you must pay for covered services before the benefits of this plan are provided. (These are called "cost shares" in this Summary Plan Document.) To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for.

The allowed amount is also explained.

You'll find the dollar amounts for these expenses and when they apply in the ***Medical Benefits Summary***.

Copayments (Copays)

Copayments ("copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service. If the amount billed is less than the copay, you only pay the amount billed. Your copay amounts are shown in the ***Medical Benefits Summary***.

Split Copay for Office Visits

This plan has two Professional Visit Copay amounts for in-network providers' office and home visits. When you see one of the types of in-network providers shown below, you pay the non-specialist copay shown in the ***Medical Benefits Summary*** for each office or home visit.

- Family practice physician
- General practice physician
- Internist
- Gynecologist
- Advanced registered nurse practitioner (ARNP)
- Obstetrician
- Pediatrician
- Physician assistant

For all other types of in-network providers covered by benefits subject to a professional visit copay, you pay the specialist copay shown in the ***Medical Benefits Summary*** for each visit.

Certain services don't require a copay. However, the Professional Visit Copay may apply if you have a consultation with the provider or receive other services. Separate copays will apply if you see more than one in-network provider on the same day. But only one copay per provider, per day will apply. If you receive multiple services from the same provider in the same visit and the copay amounts are different, then the highest copay will apply.

Calendar Year Deductible

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the "allowed amount" (see ***Allowed Amount*** below in this Summary Plan Document).

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don't count allowed amounts that apply to your individual calendar year deductible toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to your individual calendar year deductible toward that maximum.

Individual Deductible

An "Individual Deductible" is the amount each member must incur and satisfy before certain benefits of this plan are provided.

Family Deductible

We also keep track of the expenses applied to the individual deductible that are incurred by all enrolled family members combined. When the total equals a set maximum, called the "Family Deductible," we will consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member's individual deductible will count toward the family deductible.

For the HSA plan, if you transfer mid-year from a Family HSA Plan to an Individual HSA Plan and there's no lapse in your coverage, any portion of the family deductible or out-of-pocket already satisfied will be credited up to but not exceeding the new plan deductible/out-of-pocket maximum amounts to your newly selected Individual HSA Plan.

NOTE: *Only expenses incurred to satisfy the deductible and out-of-pocket in the current calendar year will be credited.*

What Doesn't Apply To The Calendar Year Deductible?

Amounts that don't accrue toward this plan's calendar year deductible are:

- Amounts that exceed the allowed amount
- Charges for excluded services
- Copays

Coinsurance

"Coinsurance" is a defined percentage of allowed amounts for covered services and supplies you receive. It's the percentage you're responsible for, not including copays and the calendar year deductible, when the plan provides benefits at less than 100% of the allowed amount. You will find your coinsurance in the ***Medical Benefits Summary***.

Out-of-Pocket Maximum

The "individual out-of-pocket maximum" is the maximum amount, made up of the cost shares below, that each individual could pay each calendar year for certain covered services and supplies. Refer to the ***Medical Benefits Summary*** for the amount of out-of-pocket maximums you're responsible for.

Once the out-of-pocket maximum has been satisfied, the benefits of this plan will be provided at 100% of allowed amounts for the remainder of that calendar year for covered services that are subject to the maximum.

Cost shares that apply toward the out-of-pocket maximum are:

- Your coinsurance; and
- The calendar year deductible.

Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay any other cost-shares shown in ***Medical Benefits Summary*** until your individual out-of-pocket maximum is reached.

- Copays

There are some exceptions. Expenses that do not apply toward the out-of-pocket maximum are:

- Charges above the allowed amount; and
- Charges not covered by the plan.

We also keep track of the total cost-shares applied to individual out-of-pocket maximums that are incurred by all enrolled family members combined. When this total equals a set maximum, called the "family out-of-pocket maximum," we will consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year. Only the amounts used to satisfy each enrolled family member's individual out-of-pocket maximum will count toward the family out-of-pocket maximum.

For the HSA plan, if you transfer mid-year from a Family HSA Plan to an Individual HSA Plan and there's no lapse in your coverage, any portion of the family deductible or out-of-pocket already satisfied will be credited up to but not exceeding the new plan deductible/out-of-pocket maximum amounts to your newly selected Individual HSA Plan.

NOTE: *Only expenses incurred to satisfy the deductible and out-of-pocket in the current calendar year will be credited.*

Allowed Amount

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us. The allowed amount is described below. There are different rules for dialysis due to end-stage renal disease and for emergency services. These rules are shown below the ***General Rules***.

General Rules

Providers In Washington and Alaska Who Have Agreements With Us

For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

Your liability for any applicable calendar year deductibles, coinsurance, copays, and amounts applied toward benefit maximums will be calculated on the basis of the allowed amount.

Providers Outside The Service Area Who Have Agreements With Other Blue Cross Blue Shield Licensees

For covered services and supplies received outside the service area, allowed amounts are determined as stated in the ***What Do I Do If I'm Outside Washington And Alaska*** section (***Out-Of-Area Care***) in this Summary Plan Document.

Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The allowed amount for providers in the service area that don't have a contract with us is the least of the three amounts shown below. The allowed amount for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the four amounts shown below:

- An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us;
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available; or
- The provider's billed charges.
- Claims may be repriced by a program manager which could reduce your responsibility.

If applicable law requires a different allowed amount than the least of the four amounts above, this plan will comply with that law.

Dialysis Due To End Stage Renal Disease

Providers Who Have Agreements With Us Or Other Blue Cross Blue Shield Licensees

The allowable charge is the amount explained above in this definition.

Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The amount the plan allows for dialysis during Medicare's waiting period will be no less than 125% of the Medicare-approved amount and no more than 90% of billed charges.

The amount the plan allows for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

See the ***Dialysis*** benefit for more details.

Emergency Services

Consistent with the requirements of the Affordable Care Act, the allowed amount will be the greatest of the following amounts:

- The median amount that Heritage network providers have agreed to accept for the same services
- The amount Medicare would allow for the same services
- The amount calculated by the same method the plan uses to determine payment to out-of-network providers

In addition to your deductible, copays, and coinsurance, if any, you will be responsible for charges received from out-of-network providers above the allowed amount.

When you receive services from providers that **don't** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowed amount, and for your normal share of the claims costs (see the ***Medical Benefits Summary*** for further detail).

The allowed amount will be the amount allowed for out-of-network providers when the provider's services are covered under this plan.

If you have questions about this information, please call us at the number listed on your Premera ID card.

HEALTH SAVINGS ACCOUNT (HSA) PLAN (YOUR FUTURE) OVERVIEW

First, here is a quick look at how this plan works. Your costs are subject to all of the following:

- **Networks.** To help control the cost of your care, this plan uses Premera's Heritage network in Washington. You may be able to save money if you use an in-network provider. For more network details, see ***How Providers Affect Your Costs***.
- **Allowed amount.** This is the most this plan allows for a covered service. It is often lower than the provider's billed charge. Providers not in one of the plan's networks have the right to bill you for amounts over the allowed amount. See ***Important Plan Information*** for details. For some covered services, you have to pay part of the allowed amount. This is called your **cost share**. This plan's cost shares are explained below. You will find the amounts in the Medical Benefits Summary.
- **Deductible.** The total allowed amount you pay in each year before this plan starts to make payments for your covered healthcare costs. You pay down the deductible with each claim. The deductible amount depends on whether a subscriber enrolls with or without a spouse and/or children. See Important Plan Information for more details.
- **Coinsurance.** For some healthcare, you pay a percentage of the allowed amount, and the plan pays the rest. This Summary Plan Document calls your percentage "coinsurance." You pay less coinsurance for many benefits when you use an in-network provider. Your coinsurance is shown in the Medical Benefits Summary.
- **Out-of-pocket maximum.** This is the most you pay each calendar year for any deductibles, copays, and coinsurance. Not all the amounts you have to pay count toward the out-of-pocket maximum. The out-of-pocket maximum amount

depends on whether a subscriber enrolls with or without a spouse and/or children. See ***Important Plan Information*** for more details.

- **Prior authorization.** Some services must be approved in advance before you get them, in order to be covered. See ***Prior Authorization*** for details about the types of services and time limits. Some services have special rules.

HOW YOUR HEALTH SAVINGS ACCOUNT (HSA) PLAN WORKS

How Providers Affect Your Costs

This plan's benefits and your out-of-pocket expenses depend on the providers you see. In this section you'll find out how the providers you see can affect this plan's benefits and your costs.

In-Network Providers

This plan is a Preferred Provider Plan (PPO). This means that the plan provides you benefits for covered services from providers in your plan's network. Its benefits are designed to provide lower out-of-pocket expenses when you receive care from in-network providers. There are some exceptions, which are explained below.

In-network providers are:

- Providers in the Heritage network in Washington. For care in Clark County, Washington, you also have access to providers through the BlueCard® Program.
- Providers in Alaska that have signed contracts with Premera Blue Cross Blue Shield of Alaska.
- For care outside the service area (see ***Definitions***), providers in the local Blue Cross and/or Blue Shield Licensee's network shown below. (These Licensees are called "Host Blues" in this Summary Plan Document.) See ***Out-Of-Area Care*** later in the Summary Plan Document for more details.
  - Wyoming: The Host Blue's Traditional (Participating) network
  - All Other States: The Host Blue's PPO (Preferred) network

In-network providers provide medical care to members at negotiated fees. These fees are the allowed amounts for in-network providers. When you receive covered services from an in-network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). This means lower cost shares for you, as shown in the ***Medical Benefits Summary***. In-network providers will not charge you more than the allowed amount for covered services. This means that your portion of the charges for covered services will be lower.

A list of in-network providers is in our Heritage provider directory. You can access the directory at any time on our Web site at www.premera.com/T-Mobile. You may also ask for a copy of the directory by calling customer service. The providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. You can also call the BlueCard provider line to locate an in-network provider. The numbers are on your Premera ID card.

We update this directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location, or their provider group is in the Heritage network.

IMPORTANT NOTE: *You're entitled to receive a provider directory automatically, without charge.*

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network provider at the in-network benefit level. However, you must request this before you get the care. See ***Prior Authorization*** to find out how to do this.

IMPORTANT NOTE

YOU WILL RECEIVE AN **ID CARD**. IT IDENTIFIES YOU AS A MEMBER WHEN YOU RECEIVE SERVICES FROM HEALTH CARE PROVIDERS. IF YOU HAVE NOT RECEIVED YOUR ID CARD OR IF YOUR CARD IS LOST OR STOLEN, NOTIFY PREMERA IMMEDIATELY AND A NEW CARD WILL BE ISSUED.

IMPORTANT PLAN INFORMATION

This section of your Summary Plan Document explains the types of expenses you must pay for covered services before the benefits of this plan are provided. (These are called "cost shares" in this Summary Plan Document.) To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for.

The allowed amount is also explained.

You'll find the dollar amounts for these expenses and when they apply in the ***Medical Benefits Summary***.

Calendar Year Deductible

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the allowed amount (see ***Allowed Amount*** below in this Summary Plan Document).

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don't count allowed amounts that apply to your in-network or out-of-network calendar year deductibles toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to your calendar year deductible toward that maximum.

Your calendar year deductible is dependent upon whether you're enrolled as an individual (subscriber only) or as part of a family (subscriber plus one or more dependents).

Subscriber-Only Deductible

When a subscriber enrolls without dependents, the subscriber must pay a fixed amount called the subscriber-only deductible before certain benefits of this plan are provided. The subscriber-only deductible does not apply to a subscriber when he or she enrolls with other family members.

Subscriber+Dependent Deductible

When a subscriber enrolls with dependents, they have a different calendar year deductible, called the subscriber+dependent deductible. This is the amount that the entire family (subscriber plus one or more enrolled dependents) must pay in total each calendar year before benefits are provided. The subscriber+dependent deductible is an "aggregate" amount, meaning that it can be met by one family member or all family members in combination. Benefits are not provided for any family member until the total subscriber+dependent deductible has been reached. This is true even if the subscriber has paid an amount equal to the subscriber-only deductible.

NOTE: *If a subscriber adds or drops dependents from coverage during the calendar year, the calendar year deductible will change to the subscriber-only or subscriber+dependent calendar year deductible when appropriate. If the subscriber adds dependents, any amounts applied to the subscriber-only deductible would be credited toward the subscriber+dependent deductible.*

What Doesn't Apply To The Calendar Year Deductible?

Amounts that don't accrue toward this plan's calendar year deductible are:

- Amounts that exceed the allowed amount; and
- Charges for excluded services.

Coinsurance

"Coinsurance" is a defined percentage of allowed amounts for covered services and supplies you receive. It's the percentage you're responsible for, not including the calendar year deductible and any copays, when the plan provides benefits at less than 100% of the allowed amount.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum amount each member could pay each calendar year for covered services and supplies furnished by in-network and out-of-network providers. This plan has 2 out-of-pocket maximums. One is for subscribers enrolling without dependents, called the subscriber-only out-of-pocket maximum. The other is for subscribers enrolling with dependents. That one is called the subscriber+dependent out-of-pocket maximum.

The subscriber+dependent out-of-pocket maximum is an "aggregate" amount, meaning that it can be met by one family member or all family members in combination. Benefits are not provided for any family member until the total subscriber+dependent out-of-pocket maximum has been reached. This is true even if the subscriber has paid an amount equal to the subscriber-only out-of-pocket maximum.

NOTE: *If a subscriber adds or drops dependents from coverage during the calendar year, the out-of-pocket maximum will change to the subscriber-only or subscriber+dependent out-of-pocket maximum when appropriate. If the subscriber adds dependents, any amounts applied to the subscriber-only out-of-pocket maximum would be credited toward the subscriber+dependent out-of-pocket maximum.*

Once the out-of-pocket maximum has been satisfied, the benefits of this plan will be provided at 100% of allowed amounts for the remainder of that calendar year for covered services from in-network and out-of-network providers.

Expenses that apply toward the out-of-pocket maximum are:

- The calendar year deductible; and
- Coinsurance.

Expenses that do not apply toward the out-of-pocket maximum are:

- Charges above the allowed amount;
- Charges not covered by the plan; and
- Your cost shares for services from out-of-network providers. However, benefits that always apply in-network cost shares, like the Emergency Room Services benefit, will apply toward the out-of-pocket maximum.

Allowed Amount

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us. The allowed amount is described below. There are different rules for dialysis due to end-stage renal disease and for emergency services. These rules are shown below the ***General Rules***.

General Rules

Providers In Washington and Alaska Who Have Agreements With Us

For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

Your liability for any applicable calendar year deductibles, copays, coinsurance, and amounts applied toward benefit maximums will be calculated on the basis of the allowed amount.

Providers Outside The Service Area Who Have Agreements With Other Blue Cross Blue Shield Licensees

For covered services and supplies received outside the service area, allowed amounts are determined as stated in the ***What Do I Do If I'm Outside Washington And Alaska?*** section (***Out-Of-Area Care***) in this Summary Plan Document.

Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The allowed amount for providers in the service area that don't have a contract with us is the least of the three amounts shown below. The allowed amount for providers outside Washington and Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the four amounts shown below:

- An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us;
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available; or
- The provider's billed charges.
- Claims may be repriced by a program manager which could reduce your responsibility.

If applicable law requires a different allowed amount than the least of the four amounts above, this plan will comply with that law.

Dialysis Due To End Stage Renal Disease

Providers Who Have Agreements With Us Or Other Blue Cross Blue Shield Licensees

The allowable charge is the amount explained above in this definition.

Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The amount the plan allows for dialysis during Medicare's waiting period will be no less than 125% of the Medicare-approved amount and no more than 90% of billed charges.

The amount the plan allows for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

See the ***Dialysis*** benefit for more details.

Emergency Services

Consistent with the requirements of the Affordable Care Act, the allowed amount for non-contracted providers will be the greatest of the following amounts:

- The median amount that Heritage network providers have agreed to accept for the same services;
- The amount Medicare would allow for the same services; or
- The amount calculated by the same method the plan uses to determine payment to out-of-network providers.

In addition to your deductible, copays, and coinsurance, you will be responsible for charges received from out-of-network providers above the allowed amount.

When you receive services from providers that **don't** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowed amount, and for your normal share of the allowed amount (see the ***Medical Benefits Summary*** for further detail).

The allowed amount will be the amount allowed for out-of-network providers even when the provider's services are covered at the in-network benefit level.

If you have questions about this information, please call us at the number listed on your Premera ID card.

HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN (YOUR CHOICE SPLIT COPAY) OVERVIEW

This section shows a summary table of the care covered by your plan. It also explains the amounts you pay. **This section does not go into all the details of your coverage. See *Covered Services* to learn more**.

First, here is a quick look at how this plan works. Your costs are subject to all of the following:

- **Networks.** To help control the cost of your care, this plan uses Premera's Heritage network in Washington. You may be able to save money if you use an in-network provider. For more network details, see ***How Providers Affect Your Costs***.
- **Allowed amount.** This is the most this plan allows for a covered service. It is often lower than the provider's billed charge. Providers not in one of the plan's networks have the right to bill you for amounts over the allowed amount. See

Important Plan Information for details. For some covered services, you have to pay part of the allowed amount. This is called your **cost share**. This plan's cost shares are explained below. You will find the amounts in the Medical Benefits Summary.

- **Copays.** These are set dollar amounts you pay at the time you get some services. If the amount billed is less than the copay, you pay only the amount billed. Copays apply to the out-of-pocket maximum unless stated otherwise in the summary. The deductible does not apply to most services that require a copay. Any exceptions are shown in the table.
  - This plan has a different copay for office visits with specialists than with non-specialists. To find out which providers get which copays, see ***How Providers Affect Your Costs***.
- **Deductible.** The total allowed amount you pay in each year for in-network and out-of-network providers' care before this plan starts to make payments for your covered healthcare costs. You pay down the deductible with each claim.
- **Coinsurance.** For some healthcare, you pay a percentage of the allowed amount, and the plan pays the rest. This Summary Plan Document calls your percentage "coinsurance." You pay less coinsurance for many benefits when you use an in-network provider. Your coinsurance is shown in the Medical Benefits Summary.
- **Out-of-pocket maximum.** This is the most you pay each calendar year for any deductibles, copays, and coinsurance. Not all the amounts you have to pay count toward the out-of-pocket maximum. See ***Important Plan Information*** for details.
- **Prior authorization.** Some services must be approved in advance before you get them, in order to be covered. See ***Prior Authorization*** for details about the types of services and time limits. Some services have special rules.

HOW YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN (YOUR CHOICE SPLIT COPAY) WORKS

How Providers Affect Your Costs

This plan's benefits and your out-of-pocket expenses depend on the providers you see. In this section you'll find out how the providers you see can affect this plan's benefits and your costs.

In-Network Providers

This plan is a Preferred Provider Plan (PPO). This means that the plan provides you benefits for covered services from providers in your plan's network. Its benefits are designed to provide lower out-of-pocket expenses when you receive care from in-network providers. There are some exceptions, which are explained below.

In-network providers are:

- Providers in the Heritage network in Washington. For care in Clark County, Washington, you also have access to providers through the BlueCard® Program.
- Providers in Alaska that have signed contracts with Premera Blue Cross Blue Shield of Alaska.
- For care outside the service area (see ***Definitions***), providers in the local Blue Cross and/or Blue Shield Licensee's network shown below. (These Licensees are called "Host Blues" in this Summary Plan Document.) See ***Out-Of-Area Care*** later in the Summary Plan Document for more details.
  - Wyoming: The Host Blue's Traditional (Participating) network
  - All Other States: The Host Blue's PPO (Preferred) network

In-network providers provide medical care to members at negotiated fees. These fees are the allowed amounts for in-network providers. When you receive covered services from an in-network provider, your medical bills will be reimbursed at a higher percentage (the in-network benefit level). This means lower cost shares for you, as shown in the ***Medical Benefits Summary***. In-network providers will not charge you more than the allowed amount for covered services. This means that your portion of the charges for covered services will be lower.

A list of in-network providers is in our Heritage provider directory. You can access the directory at any time on our Web site at www.premera.com/T-Mobile. You may also ask for a copy of the directory by calling customer service. The providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. You can also call the BlueCard provider line to locate an in-network provider. The numbers are on your Premera ID card.

We update this directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location, or their provider group is in the Heritage network.

IMPORTANT NOTE: *You're entitled to receive a provider directory automatically, without charge.*

Contracted Health Care Benefit Managers

The list of Premera's contracted Health Care Benefit Managers (HCBM) and the services they manage are available at https://www.premera.com/visitor/partners-vendors and changes to these contracts or services are reflected on the website within 30 business days.

Continuity Of Care

How Continuity of Care Works

You may qualify for Continuity of Care (COC) under certain circumstances when a provider leaves your health plan's network or your employer transitions to a new carrier. This will depend on your medical condition at the time the change occurs. COC is a process that provides you with short-term, temporary coverage at in-network levels for care received by a non-participating provider.

COC applies in these situations:

- The contract with your provider ends
- The benefits covered for your provider change in a way that results in a loss of coverage
- The contract between your company and us ends and that results in a loss of benefits for your provider

How you qualify for Continuity of Care. If a professional provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination.

- During this time, Premera will consider the professional provider to still have an agreement only while this policy remains in effect and
- For the period that is the longest of the following:
- The end of the current policy year
- Until the end of the next open enrollment period, as required under state law
- Up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment
- Through completion of postpartum care, if the member is pregnant on the date of termination; or
- Until the end of the medically necessary treatment for the medical condition if the member has a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year.

We will notify you at least 30 days prior to your provider's termination date. When a termination for cause provides us less than 30 days' notice, we will make a good faith effort to assure that a written notice is provided to you immediately.

You can request continuity of care by contacting customer service. The contact information is on the back cover of this booklet.

If you are approved for continuity of care, you will get continuing care from the terminating provider until the earliest of the following:

- The 90th day after we notified you that your provider's contract ended
- The day after you complete the active course of treatment entitling you to continuity of care

- If you are pregnant, and become eligible for continuity of care, you can continue with your provider throughout your pregnancy, plus 8 weeks of postpartum care.

Continuity of care does not apply if your provider:

- No longer holds an active license
- Relocates out of the service area
- Goes on leave of absence
- Is unable to provide continuity of care because of other reasons
- Does not meet standards of quality of care

When continuity of care ends, non-emergent care from the provider is no longer covered. If we deny your request for continuity of care, you may appeal the denial. See ***Complaints and Appeals***.

Levels of Care

Healthcare is delivered in many settings with distinct levels of care. Each level of care involves a different intensity of service to treat your medical and behavioral health symptoms. Premera covers the least intensive level of care that is medically necessary to treat your symptoms. Care is often provided in a continuum beginning with acute care and transitioning to outpatient care as symptoms or condition improve. Please see Premera medical policies for Medical Necessity criteria for each type of care.

Acute Inpatient Level of Care

- Medical, surgical or behavioral health hospitals (see ***Definitions*** for Hospital or Inpatient)

Acute facilities provide treatment for severe episodes of Illness, Injury, or behavioral health symptoms, and for recovery from surgery.

You are monitored for medical, surgical and psychiatric symptoms, with 24-hour availability of appropriate medical and psychiatric practitioners, and 24/7 onsite nursing services. Care may begin in the emergency room or an outpatient medical, surgical, or behavioral health setting with transition to an acute inpatient level of care to address your needs. Specialty-appropriate physicians, nurse practitioners, or physician assistants perform physical examinations or psychiatric evaluations within one day of hospital admission. Hospitals provide daily physical examination or psychiatric evaluation, daily nursing observation, and daily treatment during the stay. A plan for treatment and transition to lower levels of care is established shortly after admission. A brief hospital stay while on Observation is considered to be Outpatient care.

Acute care facilities are licensed by the applicable state health department as a hospital or as a behavioral health evaluation and treatment facility.

Intermediate Level Facilities

- Long-term Acute Care Hospitals (LTAC or LTACH)
- Inpatient Rehabilitation Hospitals or Units
- Skilled Nursing Facilities (see ***Definitions*** for Skilled Nursing Facility and Skilled Nursing Care)
- Residential Treatment Programs in residential treatment facilities or wilderness settings

Intermediate care facilities are a bridge between acute and outpatient care settings. They serve those who do not require the intensity of service that acute hospitals provide but are not yet ready to step down to outpatient care. Their purpose is to improve function and stabilize you for transition to outpatient services. Intermediate level facilities provide care for patients' medical needs as well as daily living support. Patients typically reside in the facility for the duration of their treatment.

Intermediate level care may be provided in a free-standing facility or in a segregated location within another facility. Wilderness programs providing behavioral health care in an outdoor setting and with the structure and intensity of a residential treatment program are also intermediate level care. Inpatient Hospice and facilities providing Custodial Care are not intermediate level facilities.

Intermediate care facilities are licensed by the applicable state health department as a healthcare or behavioral health facility. A program operating under another type of state licensure, such as a child-care license, is not an intermediate facility. Intermediate care facilities have the following characteristics:

- Onsite nursing at all times (or, for behavioral health programs, on-call nursing and onsite mental health practitioner)
- Admission evaluation or psychiatric assessment by an appropriately licensed provider by at least shortly after admission and at least weekly (every seven days) thereafter
- Daily treatment by appropriate licensed clinical providers
- A plan for treatment established shortly after admission
- Discharge planning for transition to lower levels of care

Please see Premera medical policies for Medical Necessity criteria for each type of care.

Intermediate Level Ambulatory or Outpatient Care

- Partial Hospitalization Programs for Psychiatric or Substance Use Disorder Treatment
- Intensive Outpatient Psychiatric or Substance Use Disorder Treatment Programs
- Home Health Care
- Residential Neurological Rehabilitation or Rehab Without Walls

Intermediate level outpatient programs provide intensive services to those who can function safely in a community-based setting but require a higher level of care than is provided in an outpatient office visit. Intermediate level outpatient programs may be provided by inpatient or intermediate level facilities however patients typically reside at their own homes and visit the facilities for treatment only. Some may offer programs where you can pay to reside within the facility while an outpatient level of care is provided when facility is away from your home.

Outpatient Care

- Hospital Observation
- Hospital Emergency Department
- Ambulatory Surgical Center or Outpatient Surgical Center
- Ambulatory or Outpatient Rehabilitation
- Urgent Care
- Office Visits
- Virtual Care

Outpatient care may be provided in a hospital, surgical center, clinic, or office settings, or remotely through virtual care. Outpatient services are unstructured and provide maximum freedom.

Non-Participating Providers

Non-participating providers are either (1) providers that are not in one of the networks (Out-Of-Network) shown above or (2) providers that do not have a contract with us (Non-Contracted).

Out-of-Network

Some providers in Washington have a contract with but are not in the Heritage network. In cases where this plan covers services from these providers, they will not bill you for any amount above the allowed amount for a covered service. The same is true for a provider that is in a different network of the local Host Blue plan.

There are also providers who do not have a contract with us, Premera Blue Cross Blue Shield of Alaska or the local Host Blue at all. These providers are called "non-contracted" providers in this booklet. Their covered services are based on a lower allowed

amount. See ***Important Plan Information***. "Non-contracted" providers also have the right to charge you more than the allowed amount for a covered service. You may also be required to submit the claim yourself. See ***How Do I File A Claim?*** for details.

Amounts in excess of the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

Services you receive in an in-network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are out-of-network providers. When you receive services from these out-of-network providers, you may be responsible for amounts over the allowed amount as explained above.

In-Network Benefits For Out-Of-Network Providers

The following covered services and supplies provided by out-of-network providers will always be covered at the in-network level of benefits:

- Emergency services for an emergency medical condition. (Please see the ***Definitions*** section for definitions of these terms.) This plan provides worldwide coverage for emergency services.
- The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services is an in-network provider. Emergency services furnished by an out-of-network provider will be reimbursed at the in-network benefit level. As explained above, if you see an out-of-network provider, you may be responsible for amounts that exceed the allowed amount.
- Services associated with admission by an in-network provider to an in-network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a Heritage provider who doesn't have admitting privileges at a Heritage hospital.
- Covered emergency services received from providers outside the United States.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network provider at the in-network benefit level. However, you or your out-of-network provider must request this before you get the care. See ***Prior Authorization*** to find out how to do this.

Balance Billing Protection

Non-participating providers have the right to charge you more than the allowed amount for a covered service. This is called "surprise billing" or "balance billing." However, federal law protects you from balance billing for:

Emergency Services from a nonparticipating hospital or facility or from a nonparticipating provider at the hospital or facility.

Emergency services include certain post-stabilization services you may get after you are in stable condition. These include covered services provided as part of outpatient observation or during an inpatient or outpatient stay related to the emergency visit, regardless of which department of the hospital you are in.

Non-emergency services from a **nonparticipating provider** at an **in-network hospital or outpatient surgery center.** If a non-emergency service is not covered under the in-network benefits and terms of coverage under your health plan, then the federal law regarding balance billing do not apply for these services.

Air Ambulance

Your cost sharing for non-participating air ambulance services shall be no more than if the services were provided by an in-network provider. The cost sharing amount shall be counted towards the in-network deductible and the in-network out of pocket maximum amount. Cost sharing shall be based upon the lesser of the qualifying payment amount (as defined under federal law) or the billed amount.

For the above services, you will pay no more than the plan's in-network cost shares. See the ***Summary of Your Costs***. Premera Blue Cross will work with the nonparticipating provider to resolve any issues about the amount paid. Premera will also send the plan's payments to the provider directly.

NOTE: *Amounts you pay over the allowed amount don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.*

Benefits For Out-Of-Network Or Non-Contracted Providers

The following covered services and supplies provided by out-of-network or non-contracted providers will always be covered:

- Emergency services for an emergency medical condition. (See ***Definitions*** for definitions of these terms.) This plan provides worldwide coverage for emergency services.

The benefits of this plan will be provided for covered emergency services without the need for any prior authorization and without regard as to whether the health care provider furnishing the services has a contract with us. Emergency services furnished by a non-participating provider will be reimbursed in compliance with applicable laws.

- Services from certain categories of providers to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Facility and hospital-based provider services received from a hospital that has a provider contract with Premera Blue Cross.
- Covered emergency services received from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

If a covered service is not available from an in-network provider, you can receive benefits for services provided by an out-of-network or non-contracted provider. However, you or your out-of-network provider must request this before you get the care. See ***Prior Authorization*** to find out how to do this.

IMPORTANT PLAN INFORMATION

This section of your Summary Plan Document explains the types of expenses you must pay for covered services before the benefits of this plan are provided. (These are called "cost shares" in this Summary Plan Document.) To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for.

The allowed amount is also explained.

You'll find the dollar amounts for these expenses and when they apply in the ***Medical Benefits Summary***.

Copayments (Copays)

Copayments ("copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service. If the amount billed is less than the copay, you only pay the amount billed. Your copay amounts are shown in the ***Medical Benefits Summary***.

Split Copay for Office Visits

This plan has two Professional Visit Copay amounts for in-network providers' office and home visits. When you see one of the types of in-network providers shown below, you pay the non-specialist copay shown in the ***Medical Benefits Summary*** for each office or home visit.

- Family practice physician
- General practice physician
- Internist
- Gynecologist
- Advanced registered nurse practitioner (ARNP)
- Obstetrician
- Pediatrician

- Physician assistant

For all other types of in-network providers covered by benefits subject to a professional visit copay, you pay the specialist copay shown in the ***Medical Benefits Summary*** for each visit.

Certain services don't require a copay. However, the Professional Visit Copay may apply if you have a consultation with the provider or receive other services. Separate copays will apply if you see more than one in-network provider on the same day. But only one copay per provider per day will apply. If you receive multiple services from the same provider in the same visit and the copay amounts are different, then the highest copay will apply.

Calendar Year Deductible

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the allowed amount (see ***Allowed Amount*** below in this Summary Plan Document).

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don't count allowed amounts that apply to your individual in-network or out-of-network calendar year deductibles toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to either of your individual calendar year deductibles toward that maximum.

NOTE: *Each calendar year deductible accrues toward its applicable out-of-pocket maximum, if any.*

Individual Deductible

An "Individual Deductible" is the amount each member must incur and satisfy before certain benefits of this plan are provided.

Family Deductible

We also keep track of the expenses applied to the individual deductible that are incurred by all enrolled family members combined. When the total equals a set maximum, called the "Family Deductible," we will consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member's individual deductible will count toward the family deductible.

What Doesn't Apply To The Calendar Year Deductible?

Amounts that don't accrue toward this plan's calendar year deductible are:

- Amounts that exceed the allowed amount;
- Charges for excluded services; and
- Copays.

Coinsurance

"Coinsurance" is a defined percentage of allowed amounts for covered services and supplies you receive. It's the percentage you're responsible for, not including copays and the calendar year deductible, when the plan provides benefits at less than 100% of the allowed amount. You will find your coinsurance in the ***Medical Benefits Summary***.

Out-of-Pocket Maximum

The "individual out-of-pocket maximum" is the maximum amount, made up of the cost shares below, that each individual could pay each calendar year for certain covered services and supplies. Please refer to the Medical Benefits Summary for the amount of out-of-pocket maximums you're responsible for.

Once the out-of-pocket maximum has been satisfied, the benefits of this plan will be provided at 100% of allowed amounts for the remainder of that calendar year for covered services that are subject to the maximum.

Cost shares that apply toward the out-of-pocket maximum are:

- Your coinsurance;
- The calendar year deductible; and
- Copays.

There are some exceptions. Expenses that do not apply toward the out-of-pocket maximum are:

- Charges above the allowed amount; and
- Charges not covered by the plan.

We keep track of the total cost-shares applied to the individual out-of-pocket maximum that are incurred by all enrolled family members combined. When this total equals a set maximum, called the "Family Out-of-Pocket Maximum," we will consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year. Only the amounts used to satisfy each enrolled family member's individual out-of-pocket maximum will count toward the family out-of-pocket maximum.

Allowed Amount

This plan provides benefits based on the allowed amount for covered services. We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us. The allowed amount is described below. There are different rules for dialysis due to end-stage renal disease and for emergency services. These rules are shown below the ***General Rules***.

General Rules

Providers In Washington and Alaska Who Have Agreements With Us

For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

Your liability for any applicable calendar year deductibles, coinsurance, copays, and amounts applied toward benefit maximums will be calculated on the basis of the allowed amount.

Providers Outside The Service Area Who Have Agreements With Other Blue Cross Blue Shield Licensees

For covered services and supplies received outside the service area, allowed amounts are determined as stated in the ***What Do I Do If I'm Outside Washington And Alaska?*** section (***Out-Of-Area Care***) in this Summary Plan Document.

Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The allowed amount for providers in the service area that don't have a contract with us is the least of the three amounts shown below. The allowed amount for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the four amounts shown below:

- An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us;
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available; or
- The provider's billed charges.
- Claims may be repriced by a program manager which could reduce your responsibility.

If applicable law requires a different allowed amount than the least of the four amounts above, this plan will comply with that law.

Dialysis Due To End Stage Renal Disease

Providers Who Have Agreements With Us Or Other Blue Cross Blue Shield Licensees

The allowable charge is the amount explained above in this definition.

Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The amount the plan allows for dialysis during Medicare's waiting period will be no less than 125% of the Medicare-approved amount and no more than 90% of billed charges.

The amount the plan allows for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

See the ***Dialysis*** benefit for more details.

Emergency Services

Consistent with the requirements of the Affordable Care Act, the allowed amount for non-contracted providers will be the greatest of the following amounts:

- The median amount that Heritage network providers have agreed to accept for the same services;
- The amount Medicare would allow for the same services; or
- The amount calculated by the same method the plan uses to determine payment to out-of-network providers.

In addition to your deductible, copays, and coinsurance, you will be responsible for charges received from out-of-network providers above the allowed amount.

When you receive services from providers that **don't** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowed amount, and for your normal share of the allowed amount (see the ***Medical Benefits Summary*** for further detail).

The allowed amount will be the amount allowed for out-of-network providers even when the provider's services are covered at the in-network benefit level.

If you have questions about this information, please call us at the number listed on your Premera ID card.

OUT OF AREA HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN (YOUR CHOICE) AND OUT-OF-AREA HEALTH SAVINGS ACCOUNT (HSA) PLAN (YOUR FUTURE) OVERVIEW

This plan's benefits and your out-of-pocket expenses depend on the providers you see. For individuals identified as residing outside of existing in-network provider areas, T-Mobile offers out-of-area plans. To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for. These plans will pay benefits as outlined in the ***Medical Benefits Summary*** to any licensed provider for covered medical services and supplies.

Please review the previous sections on "***How Providers Affect Your Costs***" and "***Important Plan Information***" for explanations of the types of expenses you must pay for covered services before the benefits of this plan are provided. If you still have additional questions, please call the customer service number listed on your Premera ID card.

What Do I Do If I'm Outside Washington And Alaska?

Out-of-Area Care

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera has arrangements with other Blue Cross and Blue Shield Licensees ("Host Blues") for care in Clark County, Washington and outside Washington and Alaska. These arrangements are called "Inter-Plan Arrangements." Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' in-network providers. The Host Blue is responsible for its in-network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (non-contracted providers). Out-Of-Area Care explains how the plan pays both types of providers.

You getting services through these Inter-Plan Arrangements does not change what the plan covers, benefit levels, or any stated eligibility requirements. Please call us if your care needs prior authorization.

BlueCard Program

Except for copays, we will base the amount you must pay for claims from Host Blues' in-network providers on the lower of:

- The provider's billed charges for your covered services; or
- The allowed amount that the Host Blue made available to us.

Often, the allowed amount is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

Host Blues may use a number of factors to set estimated or average prices. These may include settlements, incentive payments, and other credits or charges. Host Blues may also need to adjust their prices to correct their estimates of past prices. However, we will not apply any further adjustments to the price of a claim that has already been paid.

Clark County Providers

Services in Clark County, Washington are processed through the BlueCard Program. Some providers in Clark County do have contracts with us. These providers will submit claims directly to us, and benefits will be based on our allowed amount for the covered service or supply.

Value-Based Programs

You might have a provider that participates in a Host Blue's value-based program (VBP). Value-based programs focus on meeting standards for treatment outcomes, cost, and quality, and for coordinating care when you are seeing more than one provider. The Host Blue may pay VBP providers for meeting the above standards. If the Host Blue includes charges for these payments in the allowed amount for a claim, you would pay a part of these charges if a deductible or coinsurance applies to the claim. If the VBP pays the provider for coordinating your care with other providers, you will not be billed for it.

Taxes, Surcharges and Fees

A law or regulation may require a surcharge, tax or other fee be added to the price of a covered service. If that happens, we will add that surcharge, tax, or fee to the allowed amount for the claim.

Non-Contracted Providers

It could happen that you receive covered services from providers in Clark County, Washington and outside Washington and Alaska that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. See ***Allowed Amount*** in ***Important Plan Information*** in this Summary Plan Document for details on allowed amounts.

In these situations, you may owe the difference between the amount that the non-contracted provider bills and the payment the plan makes for the covered services as set forth above.

Blue Cross Blue Shield Global® Core

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core. Blue Cross Blue Shield Global Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***How Do I File A Claim?*** for more information. However, if you need hospital inpatient care, the service center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at 800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 804-673-1177.

More Questions

If you have questions or need to find out more about the BlueCard Program, please call our customer service department. To find a provider, go to www.premera.com/T-Mobile or call 800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

CARE MANAGEMENT

IMPORTANT NOTE

PLEASE READ THE FOLLOWING SECTIONS IN THEIR ENTIRETY FOR IMPORTANT INFORMATION ON THE **PRIOR AUTHORIZATION** PROCESS, AND ANY IMPACT IT MAY HAVE ON YOUR COVERAGE.

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important, as explained below.

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call customer service to verify that you meet the required criteria for claims payment.

Prior Authorization

You must get Premera's approval for some services before the service is performed. This process is called prior authorization.

There are two different types of prior authorization required:

1) **Prior Authorization For Benefit Coverage** You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays. This is so that Premera can confirm that these services are medically necessary and covered by the plan.

2) **Prior Authorization For In-Network Cost Shares For Out-Of-Network Providers** You must get prior authorization in order for an out-of-network provider to be covered at the plan's in-network benefit level, except for emergency services. See ***Exceptions To Prior Authorization For Out-of-Network Providers*** below for more information.

How Prior Authorization Works

We will make a decision on a request for services that require prior authorization in writing within 5 calendar days of receipt of all information necessary to make the decision. The response will let you know whether the services are authorized or not, including the reasons why. If you disagree with the decision, you can ask for an appeal. See ***Complaints and Appeals***.

If your life or health would be in serious jeopardy if you did not receive treatment right away, you may ask for an expedited review. We will respond in writing as soon as possible, but no more than 48 hours after we get all the information we need to make a decision.

Our prior authorization will be valid for 90 calendar days. This 90-day period depends on your continued coverage under the plan. If you do not receive the services within that time, you will have to ask us for another prior authorization.

1. Prior Authorization for Benefit Coverage

Medical Services, Supplies or Equipment

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.

- In-network providers or facilities are required to request prior authorization for the service.
- Out-of-network and out-of-area providers and facilities will not request prior authorization for the service. You have to ask Premera to prior authorize the service.

  It is a good idea to ask Premera for prior authorization when you see a non-contracted provider. It is to your advantage to know ahead of time if the plan is not going to cover a service, equipment, or an inpatient stay.

Exceptions To Prior Authorization For Benefit Coverage

The following services do not require prior authorization for benefit coverage, but they have separate requirements:

- Emergency services and emergency hospital admissions, including emergency drug or alcohol detox in a hospital.
- Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth.

Emergency and childbirth hospital admissions do not require prior authorization, but you must notify us as soon as reasonably possible.

2. Prior Authorization For Out-Of-Network Provider Coverage

Generally, non-emergent care by out-of-network providers is covered at a lower benefit level. However, you may ask for a prior authorization to cover the out-of-network provider at the in-network benefit level if the services are medically necessary and are only available from an out-of-network provider. You or the out-of-network provider must ask for prior authorization before you receive the services.

NOTE: It is your responsibility to get prior authorization for any services that require it when you see a provider that is out-of-network. If you do not get a prior authorization, the services will not be covered at the in-network benefit level.

The prior authorization request for an out-of-network provider must include the following:

- A statement explaining how the provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from an in-network provider; and
- Medical records needed to support the request.

If the out-of-network services are authorized, the plan will cover the service at the in-network benefit level.

However, in addition to the cost shares, you may pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Amounts over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.

Exceptions To Prior Authorization For Out-of-Network Providers

Out-of-network providers can be covered at the in-network benefit level without prior authorization for emergency services and hospital admissions for an emergency medical condition. This includes hospital admissions for emergency drug or alcohol detox or for childbirth.

If you are admitted to an out-of-network hospital due to an emergency condition, those services are always covered at the in-network benefit level. The plan will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital. If you choose to stay in the out-of-network hospital after you are medically stable and can safely transfer to an in-network hospital, you may be subject to additional charges which may not be covered by your plan.

Clinical Review

Premera has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. Our medical policies are on our website. You or your provider may review them at www.premera.com/T-Mobile. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain the information, please send your request to Care Management at the address or fax number shown below:

Premera Blue Cross
P.O. Box 327
Seattle, WA 98111-0327

Fax:1-800-843-1114

Premera reserves the right to deny payment for services that are not medically necessary or that are considered experimental/investigational. A decision by Premera following this review may be appealed in the manner described in ***Complaints And Appeals***.

In general, when there is more than one treatment option, the plan will cover the least costly option that will meet your medical needs. Premera works cooperatively with you and your physician to consider effective alternatives to hospital stays and other high-cost care to make better use of this plan's benefits.

Personal Health Support Programs

The plan offers participation in Premera'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:

- 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; and
- Finding community resources.

Participation is voluntary. To learn more about the personal health support programs, contact customer service at the phone number listed on the back of your Premera ID card.

Covered Services

This section of your Summary Plan Document describes the services and supplies that the plan covers. Benefits are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease, or injury.
- It must be medically necessary (see Definitions in this Summary Plan Document) and must be furnished in a medically necessary setting.
- It must not be excluded from coverage under this plan.
- The expense for it must be incurred while you're covered under this plan.
- It must be furnished by a "provider" (see Definitions in this Summary Plan Document) who's performing services within the scope of his or her license or certification.
- It must meet the standards set in our medical and payment policies. The plan uses policies to administer the terms of the plan. Medical policies define medical necessity criteria for specific procedures, drugs, biologic agents, devices, level of care or services. They also identify medical services that are not covered because they are experimental and investigational. Medical policies may be developed by Premera or licensed from national organizations that create evidence-based utilization standards. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at www.premera.com/T-Mobile or by calling customer service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Refer to the actual benefit provisions throughout this section and ***Exclusions*** for a complete description of covered services and supplies, limitations, and exclusions. You will find limits on days or visits and dollar limits in the ***Medical Benefits Summary***.

The ***Medical Benefits Summary*** also explains your cost shares under each benefit.

IMPORTANT NOTE

NOT EVERY SERVICE, SUPPLY THAT FITS THE DEFINITION FOR **MEDICAL NECESSITY** IS COVERED BY THE PLAN. EXCLUSIONS AND LIMITATIONS APPLY TO CERTAIN MEDICAL SERVICES, SUPPLIES AND EXPENSES. FOR EXAMPLE SOME BENEFITS ARE LIMITED TO A CERTAIN NUMBER OF DAYS, VISITS OR A DOLLAR MAXIMUM. REFER TO THE ***WHAT THE PLAN COVERS*** SECTION AND THE ***MEDICAL BENEFITS SUMMARY*** FOR THE PLAN LIMITS AND MAXIMUMS.

WHAT THE PLAN COVERS

Acupuncture

The technique of inserting thin needles through the skin at specific points on body to help control pain and other symptoms. Services must be provided by a certified or licensed acupuncturist.

This benefit covers acupuncture to:

- Relieve pain
- Provide anesthesia for surgery
- Treat a covered illness, injury, or condition

NOTE: *Acupuncture services when provided for substance use disorder conditions do not apply to the* ***Acupuncture*** *benefit visit limits.*

Allergy Testing and Treatment

Skin and blood tests used to diagnose what substances a person is allergic to, and treatment for allergies. Services must be provided by a certified or licensed allergy specialist.

This benefit covers:

- Testing
- Allergy shots
- Serums

Ambulance

This benefit covers:

- Transport to the nearest facility that can treat your condition
- Medical care you get during the trip
- Transport from one medical facility to another as needed for your condition
- Transport to your home when medically necessary

These services are only covered when:

- Any other type of transport would put your health or safety at risk
- The service is from a licensed ambulance
- It is for the member who needs transport

Air or sea emergency medical transportation is covered when:

- Transport takes you to the nearest available facility that can treat your condition

- The above requirements for ambulance services are met
- Geographic restraints prevent ground transport
- Ground emergency transportation would put your health or safety at risk

Ambulance services that are not for an emergency must be medically necessary and need prior authorization. See ***Prior Authorization*** for details.

This benefit does not cover:

- Services from an unlicensed ambulance

Assisted Reproduction

Fertility treatments are administered through Progyny. Please call (833) 281-0076 to activate benefits.

Progyny administers T-Mobile's fertility benefits and offers comprehensive coverage to assist any member wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care. If you have any questions about your fertility benefit, please call your dedicated Progyny Patient Care Advocate, or you can call Progyny customer service at (833) 281-0076.

Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to):

- Artificial Insemination (IUI), Cryopreservation of oocytes and sperm
- FDA Bloodwork and Testing
- Fresh IVF Cycle
- Frozen Embryo Transfer (FET)
- Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer)
- IVF Freeze-All
- Patient Care Advocate (PCA) Concierge Support
- Pre-authorized fertility medications (via Progyny Rx)
- PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability
- PGT-M (PGD, or Pre-implantation Genetic Diagnosis)
- Pregnancy Gap Coverage (Pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider)
- Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities), and the purchase of donor tissue (eggs and sperm)

Progyny's benefit has the following standard exclusions:

- Home ovulation prediction kits
- Services and supplies furnished by an out-of-network provider or not listed as covered in the Progyny Member Guide
- All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to laboratory tests
- Treatments that are outside the standard of care and considered experimental by the American Society of Reproductive Medicine

Blood Products and Services

- Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider

- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury

Cellular Immunotherapy And Gene Therapy

Benefits are provided for medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy. Services must meet Premera's medical policy. You can access our medical policies by contacting customer service or going to **premera.com**. Services also require prior authorization. See ***Prior Authorization***.

Drugs you get from a pharmacy are not covered. Some services need prior authorization before you get them. See ***Prior Authorization*** for details.

Chemotherapy And Radiation Therapy

Treatment which uses powerful chemicals (chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells.

Chemotherapy and radiation must be prescribed by a provider, and chemotherapy must be approved by Premera to be covered. See ***Prior Authorization***.

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions, and drugs used during chemotherapy or radiation visit
- Tooth extractions to prepare your jaw for radiation therapy

Clinical Trials

A qualified clinical trial (see ***Definitions***) is a scientific study that tests and improves treatments of cancer and other life-threatening conditions.

This benefit covers qualified clinical trial medical services and drugs that are already covered under this plan. The clinical trial must be suitable for your health condition. You also have to be enrolled in the trial at the time of treatment.

Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Professional Visits And Services*** and if you have a lab test, it's covered under ***Diagnostic X-Ray, Lab, And Imaging***.

This benefit does not cover:

- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed just to collect information for the trial)
- The drug, device or services being tested
- Travel costs to and from the clinical trial
- Housing, meals, or other non-clinical expenses
- A service that isn't consistent with established standards of care for a certain condition
- Services, supplies, or drugs that would not be charged to you if there were no coverage.
- Services provided to you in a clinical trial that are fully paid for by another source
- Services that are not routine costs normally covered under this plan

Dental Injury and Facility Anesthesia

This benefit will only be provided for the dental services listed below.

Dental Anesthesia

Anesthesia and facility care done outside of the dentist's office for medically necessary dental care

This benefit covers:

- Hospital or other facility care

- General anesthesia provided by an anesthesia professional other than the dentist or the physician performing the dental care

This benefit is covered for any one of the following reasons:

- The member is under age 19 and failed patient management in the dental office
- The member has a disability, medical or mental health condition making it unsafe to have care in a dental office
- The severity and extent of the dental care prevents care in a dental office

Dental Injury

Treatment of dental injuries to teeth, gum, and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment (excludes any orthodontia services)
- Oral surgery

This benefit is covered on sound and natural teeth that:

- Do not have decay
- Do not have a large number of restorations such as crowns or bridge work
- Do not have gum disease or any condition that would make them weak

Care is covered within 12 months of the injury. If more time is needed, please ask your doctor to contact customer service.

Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Professional Visits And Services***, and if you have a lab test it's covered under ***Diagnostic X-ray, Lab and Imaging***.

This benefit does not cover:

- Injuries from biting or chewing, including injuries from a foreign object in food
- Orthodontia services

Diagnostic X-Ray, Lab, And Imaging

Diagnostic x-ray, lab and imaging services are basic and major medical tests that help find or identify diseases.

For more information about what services are covered as preventive see ***Preventive Care***. A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

Covered services include:

- Bone density screening for osteoporosis
- Cardiac testing
- Pulmonary function testing
- Diagnostic imaging and scans such as x-rays
- Lab services
- Mammograms (including 3-D mammograms) for a medical condition
- Neurological and neuromuscular tests
- Pathology tests
- Echocardiograms

- Ultrasounds
- Diagnosis and treatment of the underlying medical conditions that may cause infertility
- Computed Tomography (CT) scan
- High technology ultrasound
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan

Diagnostic breast examination for the purpose of this ***Diagnostic X-Ray, Lab, And Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality:

- Seen or suspected from a screening examination for breast cancer; or
- Detected by another means of examination.

Supplemental breast examination for the purpose of this ***Diagnostic X-Ray, Lab, And Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is:

- Used to screen for breast cancer when there is no abnormality seen or suspected; and
- Based on personal or family medical history, or additional factors that may increase the member's risk or breast cancer.

For additional details see the following benefits:

- Emergency Room
- Hospital
- Maternity Care
- Preventive Care
- Genetic testing may be covered in some cases — call customer service before seeking testing, since it may require Prior Authorization.

Dialysis

When you have end-stage renal disease (ESRD) you may be eligible to enroll in Medicare. If eligible, it is recommended to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

Medicare has a waiting period, generally the first 90 days after dialysis starts. Benefits are different for dialysis during Medicare's waiting period than after the waiting period ends. Please see the ***Medical Benefits Summary***.

In-network providers are paid according to their provider contracts. The amount the plan pays out-of-network providers for dialysis after Medicare’s waiting period is 125% of the Medicare-approved amount, even if you do not enroll in Medicare.

When covered dialysis services are provided by an out-of-network provider in a county in Washington state where no in-network providers are available, the in-network cost shares will apply. If the dialysis services are provided by a non-contracted provider and you do not enroll in Medicare, then you will owe the difference between the non-contracted provider's billed charges and the plan's payment for the covered services. See ***Allowed Amount*** in ***Important Plan Information*** for more information.

Emergency Room

This benefit covers:

- Emergency room and provider services
- Equipment, supplies, and drugs used in the emergency room
- Services and exams used for stabilizing an emergency medical condition, including mental health, or substance use disorder condition. This includes emergency services arising from complications from a service that was not covered by the plan
- Diagnostic tests performed with other emergency services
- Emergency detoxification

You need to let us know if you are admitted to the hospital from the emergency room as soon as possible. See ***Prior Authorization*** for details.

Foot Care

This benefit covers the following medically necessary foot care services that need care from a provider:

- Foot care for members with impaired blood flow to the legs and feet when it puts the member at risk
- Treatment of corns, calluses, and toenails

This benefit does not cover:

- Routine foot care, such as trimming nails or removing corns and calluses that do not need care from a provider

Gender Affirming Care

The Plan pays Benefits for gender affirming care services including, but not limited to:

- Psychotherapy for gender dysphoria and associated comorbid psychiatric diagnoses;
- Continuous hormone therapy — hormones of the desired gender;
- All gender identity surgical services, subject to medical appropriateness outlined in the Premera medical policy; and
- Laboratory testing to monitor the safety of continuous hormone therapy.

Benefits for medically necessary gender affirming medical care or surgery are subject to the same cost shares that you would pay for inpatient or outpatient treatment for other covered medical conditions. To find the amounts you are responsible for, see the Medical Benefits Summary. If you can't find an in-network provider, or need information about what services are covered under your plan, call customer service.

Benefits are provided for all gender affirming care surgical services which meet the Premera medical policy, except that the minimum age for mastectomy and breast reduction for female-to-male and female-to-non-binary transition is 17 years old. Facility and anesthesia charges related to the surgery are also included.

Medical tattooing is covered when provided by a licensed tattoo artist, a licensed cosmetic artist, or a licensed healthcare provider, and when all other Premera medical policy criteria for medical tattooing are met.

Hair removal related to gender affirming care is covered for age 18 years old or older and a diagnosis of gender dysphoria, without any additional review.

Our medical policies are available from customer service, or at www.premera.com/T-Mobile.

NOTE: *Coverage of prescription drugs, and mental health treatment associated with gender dysphoria and gender transition, are eligible under the general plan provisions for prescription drugs and behavioral health, subject to the applicable plan limitations and exclusions. Also covered is reversal of previous gender affirming/transition surgery.*

Benefits are provided for certain travel expenses. See ***Medical Travel and Lodging*** for details.

Hearing Care

Hearing Exams

Hearing exam services include:

- Examination of the inner and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- Hearing testing services, including the use of calibrated equipment

This benefit does not cover:

- Hearing hardware or fitting examinations for hearing hardware

Hearing Hardware

To receive your hearing hardware benefit:

- You must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA) before obtaining hearing aids
- You must purchase a hearing aid device

Benefits are provided for the following:

- Hearing aids (monaural or binaural) prescribed as a result of an exam
- Ear molds as necessary to maintain optimal fit
- The hearing aid instruments, including bone conduction hearing devices and the initial assessment, adjustment and auditory training
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords, and other necessary ancillary equipment
- A warranty, when provided by the manufacturer
- A follow-up consultation within 30 days following delivery of the hearing aids with the prescribing licensed provider
- Auditory training, fitting (including adjustment, repairs, servicing, and alteration of hearing aid equipment purchased under this benefit

This benefit does not cover:

- Hearing aids purchased before your effective date of coverage under this plan
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit — these expenses are also not eligible for coverage under other benefits of this plan
- Cochlear implants (see ***Surgery*** and ***Rehabilitation Therapy*** benefits)

Hinge Health Overview

Hinge Health covers the entire continuum of MSK care. From chronic pain sufferers and those considering surgical interventions to members looking to incorporate more movement into their day with the Hinge prevention program, this comprehensive solution meets the needs of T-Mobile's entire population. Hinge combines advanced technology with the expertise of a clinical care team, to align members with care that is personalized to meet their unique goals and improve their overall quality of life.

Hinge offers care for:

- Chronic — Treat the physical and behavioral aspects of chronic MSK pain
- Acute — Recover from a specific injury
- Pre-and post-surgery — Support rehabilitation when surgery is the best course
- High Risk — Provide specialized care for complex MSK needs
- Women's Pelvic Health — Improve pelvic health for women at all stages of life
- Prevention — Prevent future injury and improve health and wellness

Hinge's model surrounds the member with high-touch support that is proven to be engaging, powerful, and effective at driving clinical and financial outcomes.

Eligibility

To be eligible for the Hinge Health programs, you and your eligible dependents must meet each of the following requirements: (i) be enrolled in a medical plan with the Hinge Health benefit, (ii) be age 18 or older, (iii) be located in the United States, and (iv) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

Cost

If you are eligible, Hinge Health is offered at no cost to you.

Hinge Health Contact Information

If you have any questions regarding Hinge Health, email help@hingehealth.com or call (855) 902-2777.

Home Health Care

General Home Health Care

General Home Health Care is short-term care performed at your home. These occasional visits are done by a medical professional that's employed through a home health agency that is state-licensed or Medicare-certified. Care is covered when a provider states in writing that care is needed in your home.

The following are covered under the ***Home Health Care*** benefit:

- Home visits and short-term nursing care
- Home medical equipment, supplies, and devices
- Prescription drugs given by the home health care agency
- Therapy, such as physical, occupational or speech therapy to help regain function

Only the following employees of a home health agency are covered:

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

The *Home Health Care* benefit does not cover:

- Over-the-counter drugs, solutions, and nutritional supplements

- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive, or respite in nature.
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food

Home Medical Equipment (HME), Orthotics, Prosthetics, and Supplies

This benefit covers:

- **Home Medical Equipment (HME)**, fitting expenses and sales tax. This plan also covers rental of HME, not to exceed the purchase price.

Covered items include:

- Wheelchairs
- Hospital beds
- Traction equipment
- Ventilators
- Diabetic equipment (e.g., an insulin pump)

Medical Supplies such as:

- Dressings
- Braces
- Splints
- Rib belts
- Crutches
- Supplies for an insulin pump

Medical Vision Hardware to correct vision due to the following medical eye conditions:

- Corneal ulcer
- Bullous keratopathy
- Recurrent erosion of cornea
- Tear film insufficiency
- Aphakia
- Sjogren's disease
- Congenital cataract
- Corneal abrasion
- Keratoconus
- Progressive high (degenerative) myopia
- Irregular astigmatism
- Aniridia
- Aniseikonia
- Anisometropia
- Corneal disorders

- Pathological myopia
- Post-traumatic disorders

External Prosthetics and Orthotic Devices used to:

- Replace absent body limb and/or
- Replace broken or failing body organ

Orthopedic Shoes and Shoe Inserts

Orthopedic shoes for the treatment of complications from diabetes or other medical disorders that cause foot problems.

Wigs or Toupees

Benefits are provided for wigs or toupees due to medically induced hair loss. Examples of medically induced hair loss include, but are not limited to, hair loss resulting from injury, disease or treatment of disease, medication, radiation therapy or chemotherapy.

You must have a written order for the items. Your doctor must state your condition and estimate the period of its need. Not all equipment or supplies are covered. Some items need prior authorization from us (see *Prior Authorization*).

This benefit does not cover:

- Hypodermic needles, lancets, test strips, testing agents and alcohol swabs.
- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Over bed tables, elevators, vision aids, and telephone alert systems
- Over-the-counter orthotic braces and/or cranial banding
- Non-wearable external defibrillators, trusses, and ultrasonic nebulizers
- Blood pressure cuffs/monitors (even if prescribed by a physician)
- Enuresis alarm
- Compression stockings which do not require a prescription
- Physical changes to your house or personal vehicle
- Orthopedic shoes used for sport, recreation, or similar activity
- Penile prostheses, except for gender affirming care
- Routine eye care
- Prosthetics, intraocular lenses, equipment, or devices which require surgery — these items are covered under the ***Surgery*** benefit

Hospice Care

To be covered, hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (MD or DO). In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without hospice services.

The plan provides benefits for covered services furnished and billed by a hospice that is Medicare-certified or is licensed or certified by the state it operates in. See the ***Medical Benefits Summary*** for limits.

Covered employees of a hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work.

The **Hospice Care** benefit covers:

- Hospice care for a terminally ill member, for up to 6 months. Benefits may be provided for up to an additional 6 months of care when needed. The initial 6-month period starts on the first day of covered hospice care.
- Palliative care for a member who has a serious or life-threatening condition that is not terminal. Coverage of palliative care can be extended based on the member's specific condition. Coverage includes expanded access to home-based care and care coordination.

Covered services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. This includes housekeeping done by a home health aide that is included in the written plan of care.
- **Respite care** to relieve anyone who lives with and cares for the terminally ill member.
- **Inpatient hospice care** — benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications, or dressings, when ordered by the attending physician.
- **Insulin and other hospice provider prescribed drugs** — benefits are provided for prescription drugs and insulin furnished and billed by a hospice.

This benefit does not cover:

- Over-the-counter drugs, solutions, and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies, or providers not in the written plan of care or not named as covered in this benefit
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, transportation, and household supplies

Hospital

This benefit covers:

- Inpatient room and board
- Provider services
- Intensive care or special care units
- Operating rooms, procedure rooms and recovery rooms
- Surgical supplies and anesthesia
- Drugs, blood, medical equipment, and oxygen for use in the hospital
- X-ray, lab, and testing billed by the hospital

Even though you stay at an in-network hospital, you may get care from doctors or other providers who do not have a network contract at all. In that case, you will not have to pay any amounts over the allowed amount for covered services.

You pay out-of-network cost shares if you get care from a provider not in your network. You will not be balanced billed for certain services provided by a non-participating provider. See ***How Providers Affect Your Costs*** for details.

We must approve all planned inpatient stays before you enter the hospital. See ***Prior Authorization*** for details.

This benefit does not cover:

- Hospital stays that are only for testing, unless the tests cannot be done without inpatient hospital facilities, or your condition makes inpatient care medically necessary
- Any days of inpatient care beyond what is medically necessary to treat the condition

Infusion Therapy

Fluids infused into the vein through a needle or catheter as part of your course of treatment.

Infusion examples include:

- Drug therapy
- Pain management
- Total or partial parenteral nutrition (TPN or PPN)

This benefit covers:

- Outpatient facility and professional services
- Professional services provided in an office or home
- Prescription drugs, supplies and solutions used during infusion therapy

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

Mastectomy and Breast Reconstruction

Benefits are provided for mastectomy necessary due to disease, illness, or injury.

This benefit covers:

- Reconstruction of the breast on which mastectomy was performed
- Surgery and reconstruction of the other breast to produce a similar appearance
- Physical complications of all stages of mastectomy, including lymphedema treatment and supplies
- Inpatient care

Planned hospital admissions require prior authorization; see ***Prior Authorization*** for details.

Maternity Care

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for all female members.

The ***Maternity Care*** benefit includes coverage for abortion. Travel and lodging benefits are available. See Medical Travel and Lodging section for details.

Facility Care

This benefit covers inpatient hospital, birth centers, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

This benefit also covers medically necessary supplies related to home births.

Professional Care

This benefit covers:

- Routine prenatal and postnatal exams and tests, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus.
- Delivery, including cesarean section, in a medical facility, or delivery in the home
- Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother — postpartum care includes services of the attending provider, a home health agency and/or registered nurse

NOTE: *Attending provider as used in this benefit means a provider such as a physician (MD or DO), a physician's assistant, a certified nurse midwife (CNM), a licensed midwife or an advanced registered nurse practitioner (ARNP). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. See the* ***Surgery*** *benefit for details on surgery coverage.*

See the ***Preventive Care*** benefit for women's preventive care during and after pregnancy.

Medical Foods

Medical foods are foods that are specially prepared to be consumed or given directly into the stomach by feeding tube under strict supervision of a doctor. They provide most of a person's nutrition. They are designed to treat a specific problem that can be detected using medical tests.

This benefit covers:

- Dietary replacement to treat inborn errors of metabolism (example phenylketonuria (PKU))
- Medically necessary elemental formula for eosinophilic gastrointestinal associated disorder
- Other severe conditions when your body cannot take in nutrient from food in the small intestine (malabsorption) disorder
- Disorders where you cannot swallow due to a blockage or a muscular problem and need to be fed through a tube

Medical foods must be prescribed and supervised by doctors or other health care providers.

This benefit does not cover:

- Food and oral nutritional supplements, and specialized infant formulas (other than those prescribed to treat the conditions listed above)
- Lactose-free or gluten-free foods

Medical Travel and Lodging

This plan provides benefits for travel and lodging only for certain covered services as described below. The member must live more than 50 miles away from the provider performing the services unless transplant protocols require otherwise. Prior approval is required.

- Organ/Tissue Transplants: Travel related to the covered transplants named in the Transplants benefit. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members not in the hospital and for their companions. The member getting the transplant must live more than 50 miles from the transplant facility unless treatment protocols require the member to remain closer to the transplant center.
- Congenital Heart Disease Services (CDH);
- Gender Affirming Care;
- Spina Bifida;
- Fertility Treatment;
- Hospice;
- Clinical Trials: Travel assistance for clinical trials (if not included with cancer treatment);
- Cancer Treatment;
- Mental Health/Substance Abuse;
- Cellular Immunotherapy and Gene Therapy;
- Reproductive Health Services;
- Obesity Treatment; and
- Other covered medical or mental health treatment that requires traveling to or staying near a treating facility that is more than 50 miles from home.

Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care with a Designated Provider and the distance from your home address to the facility or applicable provider. Eligible expenses are reimbursed after a Travel and Lodging Reimbursement Form has been completed and submitted with the appropriate receipts.

There is a combined $10,000 lifetime limit for all conditions eligible for travel and lodging assistance.

If you have specific questions regarding Medical Travel and Lodging, please call the number on the back of your ID card.

Travel and Lodging assistance is covered in-network only unless it is for Gender Affirming Care.

Benefits are provided for:

- Air transportation expenses between the member's home and the medical facility where services will be provided. Air travel expenses cover unrestricted coach class, flexible and fully refundable round-trip airfare from a licensed commercial carrier.
- Ferry transportation from the member's home community.
- Lodging expenses at commercial establishments, including hotels and motels, between home and the medical facility where the service will be provided.
- Mileage expenses for the member's personal automobile.
- Ground transportation, car rental, taxicab fares and parking fees, for the member and a companion (when covered) between the hotel and the medical facility where services will be provided.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- The eligible expenses for lodging for the patient (while not a Hospital inpatient) and one companion;
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered;
- Travel and lodging expenses are only available if the patient lives more than 50 miles from the Designated Provider, and there are no other in-network providers within 50 miles who can perform the service, and
- Reimbursement for certain lodging expenses for the patient and their companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

Premera must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The reimbursement limits and requirements can change if IRS regulations change. Please go to the IRS website, www.irs.gov, for details. This summary is not and should not be construed as tax advice.

Companion Travel

One companion needed for the member's health and safety is covered. For medically necessary care, a second companion is covered for a child under age 19.

Reimbursement of Travel Claims

You must pay for all travel expenses yourself and submit a Travel and Lodging Reimbursement Form.

A separate Travel and Reimbursement Form is needed for each patient and each commercial carrier or transportation service used. You can get Travel and Reimbursement Forms on our website at www.premera.com/T-Mobile. You can also call us for a copy of the form.

You must attach the following documents to the Travel and Reimbursement Form:

- A copy of the detailed itinerary as issued by the transportation carrier, travel agency or online travel web site
  - Itinerary must identify the names of the passengers, the dates of travel and total cost of travel, and the origination and final destination points
- Receipts for all covered travel expenses

Credit card statements or other payment receipts are not acceptable forms of documentation.

This benefit does not cover:

- Charges and fees for booking changes
- Cancellation fees
- First class airline fees
- International travel
- Lodging at any establishment that is not commercial
- Meals
- Personal care items
- Pet care, other than for service animals
- Phone service and long-distance calls
- Reimbursement for mileage rewards or frequent flier coupons
- Reimbursement for travel before contacting us and receiving prior authorization (unless travel was emergent/urgent and prior authorization was not reasonable)
- Travel for medical procedures not listed above
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network or that have not been designated by Premera to perform the services
- Travel insurance

Mental Health Care

Benefits for mental health services to manage or lessen the effects of a psychiatric condition are provided as stated below.

Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice.

Covered mental health services are:

- Inpatient care
- Outpatient therapeutic visits

  "Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Current Procedural Terminology** manual, published by the American Medical Association. Outpatient therapeutic visits can include real-time visits via telephone, online chat or text, or other electronic methods with your doctor or other provider who also maintains a physical location.
- Treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition)
- Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders

- Applied behavioral analysis (ABA) therapy for members with one of the following:
  - Autistic disorder
  - Autism spectrum disorder
  - Asperger's disorder
  - Childhood disintegrative disorder
  - Pervasive developmental disorder
  - Rett's disorder

Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all ABA services for a member may be managed by a BCBA or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques.

ABA in a School Setting:

Some portion of the direct service provision (no specific time amount is specified) may take place in the school setting when behavioral or other difficulties that are manifestations of the individual's Autism Spectrum Disorder are evident and problematic in the school setting. Direct service provision in the school setting must consist entirely of bona-fide ABA treatment activities; the ABA clinician may not be utilized as a classroom aide for the patient, as a 1:1 teacher for the patient, or in any other capacity that is a function of and the responsibility of the school system. Schools and school programs for individuals with Autism Spectrum Disorder, and tuition for specialized schools for individuals with Autism Spectrum Disorder, are non-covered activities and services because schools are not covered facility types, and educational therapy, educational services, and services that are the responsibility of school districts, and should therefore be provided by school staff, are specifically excluded from coverage. Coverage is allowed for direct service provision in the school setting that consists entirely of bona-fide ABA treatment activities, delivered by covered ABA providers.

ABA therapy must be provided by:

- A licensed physician (MD or DO) who is a psychiatrist, developmental pediatrician, or pediatric neurologist
- A licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A licensed occupational or speech therapist
- A licensed psychologist (PhD)
- A licensed community mental health agency or behavioral health agency that is also state-certified to provide ABA therapy
- A Board-Certified Behavior Analyst (BCBA)
  - This means a provider who is state-licensed if the State licenses behavior analysts (Washington does). If the state does not require a license, the provider must be certified by the Behavior Analyst Certification Board. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.
- A therapy assistant/behavioral technician/paraprofessional, when their services are supervised and billed by a licensed provider or a BCBA

Mental health services other than ABA therapy must be furnished by one of the following types of providers to be covered:

- Hospital
- State-Licensed Community Mental Health Agency
- Licensed physician (MD or DO)
- Licensed psychologist (PhD)
- A state hospital operated and maintained by the state of Washington for the care of the mentally ill

- Any other provider listed under the definition of "provider" (see Definitions in this Summary Plan Document) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license
- Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care.
- Washington state-licensed Behavioral Health Agency

When medically appropriate, services may be provided in your home.

For psychological and neuropsychological testing and evaluation benefit information, please see the ***Psychological and Neuropsychological Testing*** benefit.

For substance use disorder conditions treatment information, please see the ***Substance Use Disorder*** benefit.

The *Mental Health Care* benefit does not cover:

- Psychological treatment of sexual dysfunctions
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluation, forensic evaluations, vocational, educational, or academic placement evaluations

Neurodevelopmental (Habilitation) Therapy

Benefits are provided for the treatment of neurodevelopmental disabilities. The following inpatient and outpatient neurodevelopmental therapy services must be medically necessary to restore and improve function, or to maintain function where significant physical deterioration would occur without the therapy. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

Physical, speech and occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders, are covered under the ***Mental Health Care*** benefit.

Inpatient Care: Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility that meets our clinical standards and will only be covered when services can’t be done in a less intensive setting.

Outpatient Care: Benefits for outpatient physical, occupational and speech therapy are subject to all of the following provisions:

- The member must not be confined in a hospital or other medical facility
- Services must be furnished and billed by a hospital, rehabilitation facility that meets our clinical standards, physician, physical, occupational or speech therapist, chiropractor, or naturopath

A "visit" is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

The plan won’t provide this benefit and the ***Rehabilitation Therapy*** benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available.

This benefit does not cover:

- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn’t actively engaged in by the ill, injured, or impaired member
- Gym or swim therapy
- Custodial care

Newborn Care

Eligible newborns are covered from birth only if enrolled as described in the ***Special Provision for Newborn*** section.

Benefits are provided on the same basis as any other care, subject to the child's own cost shares, if any, and other provisions as specified in this plan. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

The ***Newborn Care*** benefit covers hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury.

Professional Care

Benefits for services received in a provider's office are subject to the terms of the ***Professional Visits And Services*** benefit. Well-baby exams in the provider's office are covered under the ***Preventive Care*** benefit. This benefit covers:

- Inpatient newborn care, including newborn exams
- Follow-up care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse
- Circumcision

NOTE: *Attending provider as used in this benefit means a provider such as a physician (MD or DO), a physician's assistant, a certified nurse midwife (CNM), a licensed midwife or an advanced registered nurse practitioner (ARNP).*

This benefit doesn't cover immunizations and outpatient well-baby exams. **See** the ***Preventive Care*** benefit for coverage of immunizations and outpatient well-baby exams**.**

Orthognathic Surgery (Jaw Augmentation Or Reduction)

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic surgery) including orthodontia are provided. Covered orthognathic surgery for repair of congenital (apparent at birth) deformities determined to be medically necessary are also covered. These procedures are not covered under other benefits of this plan.

Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician. Benefits are limited to a lifetime maximum of 30 visits.

Preventive Care

This plan pays for preventive care as shown in the ***Medical Benefits Summary***. Below is a summary of preventive care services.

Preventive Exams

- Routine adult and well-child exams. Includes exams for school, sports, and jobs
- Review of oral health for members under 19
- Vision screening for members under 19
- Depression screening

Immunizations

- Shots in a provider's office
- Flu shots, flu mist, whooping cough and other seasonal shots at a pharmacy or other community center
- Shots needed for foreign travel at the county health department or a travel clinic

Screening Tests

Routine lab tests and imaging, this includes women's preventive services as recommended by the HRSA women's preventive services guidelines and others such as:

- Mammograms (includes 3D mammograms)
- X-rays
- Pap smears
- Prostate-specific antigen tests
- BRCA genetic tests for members at risk for certain breast cancers

Pregnant Member's Care

- Breastfeeding support and counseling
- Purchase of standard electric breast pumps
- Rental of hospital-grade breast pumps if medically necessary
- Screening for postpartum depression

Colorectal Cancer Screening

Includes:

- Barium enema
- Colonoscopy, sigmoidoscopy, and fecal occult blood tests.
  - The plan also covers a consultation before the colonoscopy and anesthesia your doctor thinks is medically necessary
- If polyps are found during a screening procedure, removing them and lab tests on them are also covered as preventive
- Colonoscopies as follow-up to positive non-invasive stool-based screening tests.

Diabetes Screening

Health Education and Training

Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma. The program or class must have our approval.

Nicotine Habit-Breaking Programs

Programs to stop smoking, chewing tobacco or taking snuff.

Nutritional Counseling and Therapy

Office visits to discuss a healthy diet and eating habits and help you manage weight. The plan covers screening and counseling for:

- Members at risk for health conditions that are affected by diet and nutrition
- Weight loss for children age 6 and older who are considered obese and for adults with a body mass index of 30 kg/meter squared or higher
- Includes intensive behavioral interventions with more than one type of activity to help you set and achieve weight loss goals

Fall Prevention

Risk assessments and advice on how to prevent falls for members who are age 65 or older and have a history of falling or have mobility issues.

Pre-Exposure Prophylaxis (PrEP)

A daily medicine for members at high risk for HIV infection

Contraceptives

- Contraceptive devices, shots, and implants.
- Tubal ligation
  - When tubal ligation is done as a secondary procedure, only the charge for the procedure itself is covered under this benefit — related services, such as anesthesia, are covered as part of the primary procedure (see ***Hospital*** and ***Surgery***)

About Preventive Care

Preventive care is a set of evidence-based services. These services are based on guidelines required under state or federal law. The guidelines come from:

- Services that the United States Preventive Services Task Force has given an A or B rating
- Immunizations that the Centers for Disease Control and Prevention recommends
- Screening and other care for women, babies, children, and teens that the Health Resources and Services Administration recommends
- Services that meet the standards in Washington state law

Please go to this government website for more information: https://www.healthcare.gov/coverage/preventive-care-benefits/

The agencies above may also change their guidelines from time to time. If this happens, the plan will comply with the changes.

Some preventive services and tests have limits on how often you should get them. The limits are often based on your age or gender. For some services, the number of visits covered as preventive depends on your medical needs. After one of these limits is reached, these services are not covered in full, and you may have to pay more out-of-pocket costs.

Some of the covered services your provider does during a routine exam may not be preventive at all. The plan would cover them under other benefits. They would not be covered in full.

For Example:

During your preventive exam, your provider may find a problem that needs further tests or screening for a proper diagnosis to be made. Or, if you have a chronic disease, your provider may check your condition with tests. These types of tests help to diagnose or monitor your illness and would not be covered under the ***Preventive Care*** benefit. You would have to pay the cost share under the plan benefit that covers the service or test.

The Preventive Care benefit does not cover:

- Take-home drugs or over-the-counter items
- Routine newborn exams while the child is in the hospital after birth (see **Newborn Care**)
- Routine or other dental care
- Services related to tubal ligation when it is done as a secondary procedure. The charge for the procedure itself is covered under this benefit, but the related services, such as anesthesia, are covered as part of the primary procedure. See the ***Hospital*** and ***Surgery*** benefits.
- Routine vision and hearing exams
- Gym fees or exercise classes or programs
- Services or tests for a specific illness, injury or set of symptoms (see the plan's other benefits)
- Physical exams for basic life or disability insurance
- Work-related disability or medical disability exams
- Purchase of hospital-grade breast pumps

Private Duty Nursing (Skilled Hourly Nursing)

Benefits are provided for medically necessary special nursing care by a registered nurse or a licensed practical nurse. The member must be homebound, in lieu of hospitalization with a written treatment plan by a physician.

Professional Visits And Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home. Benefits are also provided for the following professional services when provided by a qualified provider:

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see **Definitions**)
- Repair of a dependent child's congenital anomaly
- Consultations with a pharmacist
- Real-time visits via online and telephonic methods with your doctor or other provider who also maintains a physical location

For surgical procedures performed in a provider's office, surgical suite or other facility benefit information, see the ***Surgery*** benefit.

For professional diagnostic services benefit information, see the ***Diagnostic X-Ray, Lab, And Imaging*** benefit.

For home health or hospice care benefit information, see the ***Home Health Care*** and ***Hospice Care*** benefits.

For preventive or routine services, see the ***Preventive Care*** benefit.

For diagnosis and treatment of psychiatric conditions benefit information, see the ***Mental Health Care*** benefit.

For diagnosis and treatment of temporomandibular joint (TMJ) disorders benefit information, see the ***Temporomandibular Joint Disorders (TMJ) Care*** benefit.

This benefit does not cover:

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic, or homeopathic medicines or devices
- Services used to improve your appearance, such as services to increase hair growth or alter the appearance of your skin

Psychological and Neuropsychological Testing

Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results. Physical, occupational or speech therapy assessments and evaluations for rehabilitation are provided under the ***Rehabilitation Therapy*** benefit.

See the ***Neurodevelopmental (Habilitation) Therapy*** benefit for physical, occupational or speech therapy assessments and evaluations related to neurodevelopmental disabilities.

Rehabilitation Therapy

This plan covers rehabilitation therapy. Benefits must be provided by a licensed physical therapist, occupational therapist, speech language pathologist or a licensed qualified provider.

Rehabilitation therapy is therapy that helps get a part of the body back to normal health or function. It includes therapy to 1) restore or improve a function that was lost because of an accidental injury, illness, or surgery; or 2) to treat disorders caused by a physical congenital anomaly.

Services provided for treatment of a mental health condition are provided under the ***Mental Health Care*** benefit.

Chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases are covered as any other medical condition and do not accrue to rehabilitation therapy limits.

Limits listed in the ***Medical Benefits Summary*** do not apply to rehabilitation related to treatment of cancer, such as for breast cancer rehabilitation therapy.

Inpatient Care

Inpatient rehabilitation care is covered when medically necessary and provided in a specialized inpatient rehabilitation center, which may be part of a hospital. If you are already an inpatient, this benefit will start when your care becomes mainly rehabilitative, and you are transferred to an inpatient rehabilitation center. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary.

You must get prior authorization from us before you get treatment in an inpatient rehabilitation center. See ***Prior Authorization*** for details.

Outpatient Care

This benefit covers the following types of outpatient therapy:

- Physical, speech, hearing, and occupational therapies
  - Physical, speech, and occupational assessments and evaluations related to rehabilitation are also covered
- Cochlear implants
- Home medical equipment, medical supplies, and devices

This benefit does not cover:

- Treatment that the ill, injured, or impaired member does not actively take part in.
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's injury or illness or from the date of the member's surgery that made the rehabilitation necessary.
- Therapy for flat feet except to help you recover from surgery to correct flat feet.

Skilled Nursing Facility Care

This benefit includes:

- Room and board
- Skilled nursing services
- Supplies and drugs
- Skilled nursing care during some stages of recovery
- Skilled rehabilitation provided by physical, occupational or speech therapists while in a skilled nursing facility
- Short or long term stay immediately following a hospitalization
- Active supervision by your provider while in the skilled nursing facility

We must approve all planned skilled nursing facility stays before you enter a skilled nursing facility. See ***Prior Authorization*** for details.

This benefit does not cover:

- Acute nursing care
- Skilled nursing facility stay not immediately following hospitalization or inpatient stay
- Skilled nursing care outside of a hospital or skilled nursing facility
- Care or stay provided at a facility that is not qualified per our standards

Spinal and Other Manipulations

This benefit covers medically necessary manipulations to treat a covered illness, injury, or condition.

Rehabilitation therapy, such as physical therapy is covered under the ***Rehabilitation Therapy*** and ***Neurodevelopmental (Habilitation) Therapy*** benefits.

Substance Use Disorder

This benefit covers inpatient and outpatient substance use disorder conditions treatment and supporting services.

Covered services include services provided by a state-approved treatment program or other licensed or certified provider. Covered outpatient visits can include real-time visits via telephone, online chat or text, or other electronic methods with your doctor or other provider who also maintains a physical location.

The current edition of the **Patient Placement Criteria for the Treatment of Substance Related Disorders** as published by the American Society of Addiction Medicine is used to determine if substance use disorder conditions treatment is medically necessary.

NOTE: *Medically necessary detoxification is covered in any medically necessary setting. Detoxification in the hospital is covered under the* ***Emergency Room*** *and* ***Hospital*** *benefits. Acupuncture services when provided for substance use disorder conditions do not apply to the Acupuncture benefit visit limits.*

This benefit does not cover:

- Halfway houses, quarter way houses, recovery houses, and other sober living residences

Surgery

This benefit covers surgical services (including injections) that are not named as covered under other benefits, when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office. Also covered under this benefit are:

- Anesthesia or sedation and postoperative care as medically necessary
- Cornea transplantation, skin grafts, repair of a dependent child's congenital anomaly, and the transfusion of blood or blood derivatives
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services as described in the ***Preventive Care*** benefit
- Surgery that is medically necessary to correct the cause of infertility
- Does not include assisted reproduction techniques
- Repair of a defect that is the direct result of an injury, providing such repair is started within 12 months of the date of the injury
- Correction of functional disorders upon our review and approval
- Vasectomy
- Reversals of voluntary sterilization

For organ, bone marrow or stem cell transplant procedure benefit information, see the ***Transplants*** benefit.

For services to change gender, see the ***Gender Affirming Care*** benefit.

This benefit does not cover removal of excess skin or fat related to either weight loss surgery or the use of drugs for weight loss.

Surgical Center Care — Outpatient

Benefits are provided for services and supplies furnished by an outpatient surgical center.

Temporomandibular Joint Disorders (TMJ) Care

TMJ disorders are covered on the same basis as any other condition.

TMJ disorders include those conditions that have some of the following symptoms:

- Muscle pain linked with TMJ
- Headaches linked with the TMJ
- Arthritic problems linked with the TMJ
- Clicking or locking in the jawbone joint
- An abnormal range of motion or limited motion of the jawbone joint

This benefit covers:

- Exams
- Consultations
- Treatment

Some services may be covered under other benefits sections of this plan with different or additional cost share, such as:

- X-rays. See Diagnostic X-Ray, Lab, and Imaging.
- Surgery See Surgery.
- Hospital See Hospital.

Some surgeries need prior authorization before you get them. See ***Prior Authorization*** for details.

"Medical Services" for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food
- Recognized as effective, according to the professional standards of good medical practice
- Not experimental or investigational, according to the criteria stated under Definitions, or primarily for cosmetic purposes

"Dental Services" for the purpose of this TMJ benefit are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food
- Recognized as effective, according to the professional standards of good dental practice
- Not experimental or investigational, according to the criteria stated under Definitions, or primarily for cosmetic purposes

Therapeutic Injections

This benefit covers:

- Shots given in the provider's office
- Supplies used during the visit, such as serums, needles, and syringes
- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

- Immunizations. See ***Preventive Care.***
- Self-injectable drugs.
- Allergy shots. See ***Allergy Testing and Treatment***.
- Transplants

The ***Transplants*** benefit is not subject to a separate benefit maximum other than the maximum for travel and lodging described below. This benefit covers medical services provided by in-network and out-of-network providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about Approved Transplant Centers.

Covered Transplants

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (See ***Definitions*** in this Summary Plan Document for the definition of "experimental/investigational services.") The plan reserves the right to base coverage on all of the following:

- Organ transplants and bone marrow / stem cell reinfusion procedures must meet the plan's criteria for coverage
  - The medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives are all reviewed
- The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are:
  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney
  - Pancreas
  - Pancreas with kidney
  - Bone marrow (autologous and allogeneic)
  - Stem cell (autologous and allogeneic)

NOTE: *For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives other than bone marrow or stem cells. These procedures are covered on the same basis as any other covered surgical procedure (see the* ***Surgery*** *benefit).*

Your medical condition must meet the plan's written standards.

The transplant or reinfusion must be furnished in an Approved Transplant Center. (An "Approved Transplant Center" is a hospital or other provider that's developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and meets the other approval standards we use.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of Approved Transplant Centers around the country. Whenever medically possible, we'll direct you to an Approved Transplant Center that we've contracted with for transplant services.

Of course, 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.

Recipient Costs

This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs

Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Travel And Lodging

Benefits are provided for certain travel expenses related to services provided by an approved transplant provider. See ***Medical Travel and Lodging*** for details.

The Transplant benefit does not cover:

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, that are not specifically stated under this benefit
- Services and supplies that are payable by any government, foundation, or charitable grant — this includes services performed on potential or actual living donors and recipients, and on cadavers
- Donor costs for an organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (see ***Definitions*** in this Summary Plan Document)
- Personal care items
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future

Urgent Care

This benefit covers:

- Exams and treatment of:
  - Minor sprains
  - Cuts
  - Ear, nose, and throat infections
  - Fever

Some services done during the urgent care visit may be covered under other benefits of this plan with different or additional cost shares, such as:

- X-rays and lab work
- Shots or therapeutic injections
- Office surgeries

Urgent care centers can be part of a hospital or not. See the ***Medical Benefits Summary*** for information about each type of center you may visit.

Virtual Care

Virtual care uses interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Services must meet the following requirements:

- Covered service under this plan:

- Originating site: Hospital, rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center
- If the service is provided through store and forward technology, there must be an associated office visit between the member and the referring provider.
- Is Medically Necessary

This does not include services such as facsimile, email communication and SMS messages (texts) or services that are not HIPAA compliant and secured.

See the ***Medical Benefits Summary*** for the types of virtual visits covered by this benefit.

This benefit does not cover real-time visits using online and telephonic methods between you and your doctor or other provider who also maintains a physical location. These visits are covered under the ***Professional Visits And Services*** benefit and other benefits of this plan.

Weight Management (Bariatric Surgery)

Non-Surgical Weight Management

Benefits for non-surgical weight management are covered on the same basis as any other covered condition, subject to the applicable benefits, limitations, and exclusions.

Non-surgical weight management benefits include, but aren't limited to, coverage of the following outpatient medical services:

- Behavioral health visits
- Nutritional/dietician visits
- Physical therapy visits
- Physician visits
- Related lab and diagnostic services

For specific benefit information, see the ***Mental Health Care, Preventive Care, Rehabilitation Therapy, Professional Visits and Services,*** and ***Diagnostic X-Ray, Lab, and Imaging*** benefits.

Surgical Weight Loss Treatment

Benefits for surgical treatment of morbid obesity are covered the same as any other covered condition subject to the criteria listed below, applicable benefits, limitations, and exclusions. Benefit is limited to one surgery per lifetime, unless there are complications or as part of a planned two-stage procedure for patients with a Body Mass Index (BMI) of 50 kg/m2. A second surgery must take place within three years of the initial surgery.

Weight loss surgery requires prior authorization. See ***Prior Authorization*** in this Summary Plan Description.

Coverage is available for bariatric procedures listed as medically necessary when conservative measures have proven ineffective. Examples of conservative measures include but aren't limited to covered services under the Non-Surgical Weight Management benefit, diet, and exercise programs.

To qualify for surgical weight loss treatment, the member must meet a minimum BMI of 37.5 kg/m2 or a minimum BMI of 32.5 kg/m2 in the presence of one or more comorbidities as outlined in the Claims Administrator's medical policy on bariatric surgery. See the Bariatric Surgery medical policy at www.premera.com/T-Mobile. For specific surgical treatment benefit information, see the ***Hospital, Surgical Center Care — Outpatient*** and ***Surgery*** benefits.

The *Weight Management* benefit does not cover:

- Procedures or treatments that are experimental and investigational (see ***Definitions*** in this Summary Plan Document)
- Liposuction or surgical removal of excess skin unless medically necessary
- Liquid diet or fasting programs
- Other food replacement and nutritional supplements

- Membership in diet programs
- Exercise programs and health clubs
- Wiring of the jaw
- Members under the age of 12

Benefits are provided for certain travel expenses. See ***Medical Travel and Lodging*** for details.

MEDICAL GENERAL EXCLUSIONS AND LIMITATIONS

This Plan will not pay or approve benefits for any of the services, supplies, items, or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies received before an Employee or their Dependent becomes covered under this Plan.
- Services or supplies received after the date an Employee or their Dependent's coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under this Plan. (An Employee may not be enrolled as both an Employee and a Dependent under the Plan.).
- A procedure or surgery to remove fatty tissue such as panniculectomy (except when medically necessary), abdominoplasty, thighplasty, brachioplasty, or mastopexy.
- Orthotic appliances and devices, except when all of the following are met:
  - Prescribed by a Physician for a medical purpose; and
  - Custom manufactured or custom fitted to an individual Covered Person.

    NOTE: *Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics, cranial bands, or any braces that are obtained without a Physician's order. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.*
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Chelation therapy, except to treat heavy metal poisoning.
- Any charges for completion of claim forms, missed appointments, room or facility reservations or record processing.
- Any charge for services, supplies or equipment advertised by the provider as free.
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency. Any charges prohibited by a federal anti-kickback or self-referral statues.
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
- Breast reduction surgery that is determined to be a Cosmetic Procedure, except those provided for Gender Affirming Care. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures.
- Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.
  - Care that meets one of these conditions is custodial care regardless of any of the following:
    - Who recommends, provides, or directs the care;
    - Where the care is provided; or

  - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Domiciliary care.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
  - This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials
- Eyeglasses, contact lenses, eye refractions, unless required due to an accidental injury or cataract surgery (the Plan covers only the first pair of glasses or contact lens following cataract surgery). Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
- Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition.
- Health services for which you have no legal responsibility to pay and for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Herbal medicine, holistic or homeopathic care, including drugs, however the Covered Health Services of naturopathic physicians are covered services.
- Services, supplies, medical care, or treatment given by a family member by birth or marriage, including:
  - The Employee's Spouse; and
  - The Child, brother, sister, parent, or grandparent of either the Employee or the Employee's Spouse.

    NOTE: *This includes any service the provider may perform on himself or herself. This also includes in-laws and step relatives.*
- Services performed by a provider with the same legal residence.
- Services performed at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service; or
  - Is not actively involved in your medical care after the service is received.

    NOTE: *This exclusion does not apply to mammography testing.*
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided under Reconstructive Procedures or Gender Affirming Care.
- Surgical correction or other treatment of malocclusion. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or if required due to cancer. Orthognathic surgery and jaw alignment, except as treatment of obstructive sleep apnea. Medically necessary reconstructive Orthognathic Surgery is covered. Orthognathic services that are considered cosmetic are excluded. Services or supplies that are not Covered Health Services, including any confinement or treatment given in connection with a service or supply which is not Covered Health Services.
- Massage therapy, including any services provided by a Massage Therapist.

- Membership costs for health clubs, weight loss clinics and similar programs.
- Medical and surgical treatment of excessive sweating (hyperhidrosis), except Botox.
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Snoring appliances.
- Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* or to Benefits provided under *Non-Preventive Nutritional Counseling*.

  NOTE: *Obesity-related nutritional counseling is covered as preventive.*
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
- For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, and hot tubs.
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, employment, insurance, marriage, or adoption;
  - Conducted for purposes of medical research; or
  - Related to judicial or administrative proceedings or orders unless Medically Necessary; or
  - Required to obtain or maintain a license of any type.
- Private duty nursing services while confined in a facility.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
- Health services for organ and tissue transplants, except those described in ***Transplants***. Health services for transplants involving animal organs. Multiple organ transplants not listed as a Covered Health Service under ***Transplants***, unless determined by the medical claims administrator to be a proven procedure for the involved diagnosis/diagnoses.
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under this Plan and is undergoing a covered transplant.
- Respite care; this exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under ***Hospice Care***.
- Sensitivity training, educational training therapy or treatment for an education requirement.
- Travel or transportation expenses, even if ordered by a Physician, except as identified under ***Travel and Lodging*** or elsewhere in this SPD.
- Stand-by services required by a Physician.
- Except as defined under ***Orthognathic Surgery*** and ***Dental Injury and Facility Anesthesia***, care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, orthodontia, extractions, implants, or any treatment to improve the ability to chew or speak. See ***Orthognathic Surgery*** and ***Dental Injury and Facility Anesthesia*** for limited coverage of oral surgery and dental services.

- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Special foods, food supplements, liquid diets, diet plans or any related products, unless allowed under the ***Nutritional Supplements/Enteral Feeding*** provision.
- Services for the evaluation and treatment of Temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances.
- Weight loss surgery for individuals under age 18.
- Weight loss treatment (except as a part of the Obesity Surgery benefit).
- Wigs or toupees (except for medically induced hair loss in all diagnosed situations), hair transplants, or hair weaving.
- Services given by volunteers or persons who do not normally charge for their services.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing, treatment of non-specific candida sensitivity and urine auto injections.
- Services provided to someone other than the ill or injured member. This includes health care provider training or educational services.
- Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*.
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Transitional Living services (including recovery residences).
- Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
- Residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment. Treatment in wilderness programs or other similar programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution), except for that portion of treatment that would otherwise be eligible health services under this Plan (e.g., individual counseling).
- Expenses for health services and supplies that exceed Eligible Expenses or any specified limitation in the SPD.
- Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider's license.
- Counseling, education or training in the absence of illness.
    - Job help and outreach, social or fitness counseling:
        - Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff.
        - Private school or boarding school tuition.
- Any health examinations required:
    - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement; or
    - By any law of a government.

- Growth/Height: Any treatment, device, drug, service, or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Any hearing service or supply that does not meet professionally accepted standards.
- 0063equipment or device.
- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies including: 1) annual or other charges to be in a physician's practice; 2) Charges to have preferred access to a physician's services.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).
- Non-medically necessary services, including but not limited to, those treatments, services and supplies which are not medically necessary, as determined by the medical claims administrator, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended, or approved by your physician or dentist.
- Over-the-counter hearing aids.
- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Sexual dysfunction/enhancement.
- Strength & Performance: Services, devices, and supplies to enhance strength, physical condition, endurance, or physical performance.
- Therapies and tests: Generally, any of the following treatments or procedures:
  - Aromatherapy;
  - Carbon dioxide therapy;
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
  - Massage therapy;
  - Megavitamin therapy;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Thermograms and thermography.
- Transplant: The transplant coverage does not include charges for:
  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services and supplies furnished to a donor when recipient is not a covered person;
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;

  - Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by the medical claims administrator when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.
- Benefits are not provided for low-level laser therapy.
- Recreational, camp and activity-based programs. These programs are not medically necessary and include:
  - Gym, swim and other sports programs, camps and training;
  - Creative art, play and sensory movement and dance therapy;
  - Recreational programs and camps;
  - Hiking, tall ship, and other adventure programs and camps;
  - Boot camp programs and outward-bound programs;
  - Equine programs and other animal-assisted programs and camps; and
  - Exercise and maintenance-level programs.
- Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-network providers may not bill members for these services and members are held harmless.
  - Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
  - Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.
  - Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed on your Premera Blue Cross ID card or on the Centers for Medicare and Medicaid Services (CMS) Web page at www.cms.hhs.gov.
- This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware.
- This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
- Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous.
- Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
  - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
  - Medically Necessary.
  - Described as a Covered Health Service in this SPD under *Additional Coverage Details* and *Plan Highlights*.
  - Not otherwise excluded in this SPD under *Exclusions and Limitations*.
- Services or supplies if provision of the services or supplies are illegal under the applicable state law where the services or supplies are provided.

HEALTH SAVINGS ACCOUNT — PREMERA

Introduction

This section describes some key features of the Health Savings Account (HSA) that you could establish to complement the Health Savings Account (HSA) Plan, which is a high deductible health plan.

T-Mobile USA, Inc. has entered into an agreement with Premera under which ConnectYourCare LLC, a subsidiary of Optum Financial, Inc. will provide certain administrative services to the Plan.

OPTUM FINANCIAL DOES NOT INSURE THE BENEFITS DESCRIBED IN THIS SECTION. FURTHER, NOTE THAT IT IS THE PLAN'S INTENTION TO COMPLY WITH DEPARTMENT OF LABOR GUIDANCE SET FORTH IN FIELD ASSISTANCE BULLETIN NO. 2004-1, WHICH SPECIFIES THAT AN HSA IS NOT AN ERISA PLAN IF CERTAIN REQUIREMENTS ARE SATISFIED.

THE HSA DESCRIBED IN THIS SECTION IS NOT AN ARRANGEMENT THAT IS ESTABLISHED AND MAINTAINED BY T-MOBILE USA, INC. RATHER, THE HSA IS ESTABLISHED AND MAINTAINED BY THE HSA TRUSTEE. HOWEVER, FOR ADMINISTRATIVE CONVENIENCE, A DESCRIPTION OF THE HSA IS PROVIDED IN THIS SECTION.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible health plan described in this document.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax-free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses; however, these amounts are subject to income tax and may be subject to 20 percent penalty.

You have three tools you can use to meet your health care needs:

- Health Savings Account (HSA) Plan, a high deductible health plan which is discussed in this document;
- An HSA you establish; and
- Health information, tools, and support.

Benefits available under your medical plan are described in this document.

WHAT IS AN HSA?

AN HSA IS A TAX-ADVANTAGED ACCOUNT T-MOBILE PARTICIPANTS CAN USE TO PAY FOR QUALIFIED HEALTH EXPENSES THEY OR THEIR ELIGIBLE DEPENDENTS INCUR. HSA CONTRIBUTIONS:

- ACCUMULATE OVER TIME WITH INTEREST OR INVESTMENT EARNINGS;
- ARE PORTABLE AFTER EMPLOYMENT; AND
- CAN BE USED TO PAY FOR QUALIFIED HEALTH EXPENSES TAX-FREE OR FOR NON-HEALTH EXPENSES ON A TAXABLE BASIS.

Who Is Eligible and How to Enroll

Eligibility to participate in the Health Savings Account is described in this document for your high deductible health plan. You must be covered under a high deductible health plan in order to participate in the HSA. In addition, you:

- Must not be covered by any high deductible health plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Must not participate in a full health care Flexible Spending Account (FSA);
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare); and
- Must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by T-Mobile USA, Inc. or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to reasonable administrative restrictions imposed by the trustee (e.g., minimum deposit, balance, and distribution requirements; distribution timing requirements; account fees).

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

NOTE: *If coverage under a qualified high deductible health plan terminates, any further contributions made to the HSA will not qualify for the tax benefits applicable to HSAs.*

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) and remain HSA-eligible as of December 1 of that year, you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and remain HSA-eligible through December 31st of the following year or you will be subject to tax implications and an additional tax of 10%.

The IRS also allows you to make an extra catch-up deposit of $1,000 annually, if you are 55 or older.

NOTE: *Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to the deadline for filing your federal income tax return (including any extensions) for the year the contributions were made.*

How Much Money is Allocated to Your HSA — Employer Contributions

T-Mobile USA, Inc. will currently allocate a specified amount of funds to your HSA on a calendar Plan year basis specific to the coverage category you enroll in, not to exceed $500 for individual coverage and $1,000 for family coverage annually. Amounts are pro-rated per pay period. The table below contains the details for the employer contribution to your HSA:

Coverage Category	Per Pay Period Contribution to HSA
Employee	$19.23
Employee plus Spouse	$38.46
Employee plus Child(ren)	$38.46
Family	$38.46

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductible and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Carry Over Feature

If you do not use all of the funds in your HSA during the calendar plan year, the balance remaining in your HSA will carry over. If your employment terminates, you continue to own and control the funds in your HSA, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in this document.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

IMPORTANT

BE SURE TO KEEP YOUR RECEIPTS AND MEDICAL RECORDS. SINCE HSA CONTRIBUTIONS ARE PRE-TAX, YOU CAN EITHER HAVE THE CONTRIBUTIONS DEDUCTED FROM YOUR PAYCHECK ON A PRE-TAX BASIS OR DEDUCT THE CONTRIBUTION AMOUNT FROM YOUR INCOME ON YOUR TAX RETURN SO THAT YOU DON'T END UP PAYING TAXES ON THE CONTRIBUTIONS. HOWEVER, IF YOU CANNOT DEMONSTRATE THAT YOU USED YOUR HSA TO PAY QUALIFIED HEALTH EXPENSES, YOU MAY NEED TO REPORT THE DISTRIBUTION AS TAXABLE INCOME ON YOUR TAX RETURN. T-MOBILE USA, INC. AND PREMERA WILL NOT VERIFY THAT DISTRIBUTIONS FROM YOUR HSA ARE FOR QUALIFIED HEALTH EXPENSES. CONSULT YOUR TAX ADVISOR TO DETERMINE HOW YOUR HSA AFFECTS YOUR UNIQUE TAX SITUATION.

THE IRS MAY REQUEST RECEIPTS DURING A TAX AUDIT. T-MOBILE USA, INC. AND THE CLAIMS ADMINISTRATOR ARE NOT RESPONSIBLE OR LIABLE FOR THE MISUSE BY PARTICIPANTS OF HSA FUNDS BY, OR FOR THE USE BY PARTICIPANTS OF HSA FUNDS FOR NON-QUALIFIED HEALTH EXPENSES.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, Premera and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will Premera provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify and the financial institution in writing.

IMPORTANT NOTE FOR HSA ENROLLEES: Once you enroll in the HSA Plan with Premera or UHC, you may be asked to provide additional information before your HSA account can be opened. This is a requirement under federal law as part of the USA PATRIOT Act. If you have to provide additional information, you will be notified by Premera or UHC and allowed a period of time within which to respond. If you do not provide the requested information by the applicable deadline, your request to open an HSA account will need to be closed. This means you won't have an HSA to use for your out-of-pocket healthcare expenses. Any HSA contributions that were withheld from your pay, or employer HSA contributions that were scheduled to be made by T-Mobile, won't be available in an HSA for you. The HSA contributions that were withheld from your pay will be returned to you as taxable income, and HSA contributions will stop being withheld from your pay. In addition, any T-Mobile employer HSA contributions that were scheduled to be made will be forfeited. However, if at some point in the future you request to reopen your application to open your HSA account, you will need to elect to restart both the T-Mobile employer and your individual HSA contributions to be withheld from your pay beginning within 1-2 pay periods from the request. Your own HSA contributions and T-Mobile's employer HSA contributions will only be made on a prospective basis once you have provided the information required to open your HSA account and your HSA account has in fact been officially opened. For help with any HSA-related questions: Premera enrollees contact (866) 358-2300 and UHC enrollees contact (877) 259-1527.

YOU CAN OBTAIN ADDITIONAL INFORMATION ON YOUR HSA ONLINE AT WWW.IRS.GOV. YOU MAY ALSO CONTACT YOUR TAX ADVISOR. PLEASE NOTE THAT ADDITIONAL RULES MAY APPLY TO A DEPENDENT'S INTENT TO OPENING AN HSA.

HEALTH REIMBURSEMENT ACCOUNT PLAN — PREMERA

This Section describes the healthcare expense reimbursement component of the Plan. It includes summaries of:

- What is a Health Reimbursement Account (HRA) Plan;
- Who is Eligible and How to Enroll;
- How the HRA Plan Works;
- New Hires and Adjustments for Status Changes;
- What Type of Expenses Qualify for Reimbursement from the HRA;
- What Happens to Remaining Balances in Your HRA; and
- HRA Claims Procedures.

This Section of the Summary Plan Description (SPD) describes the Employer-sponsored Health Reimbursement Account (HRA) Plan.

T-Mobile USA, Inc. has entered into an agreement with Premera under which Optum Financial will process eligible healthcare expense reimbursements through the HRA and provide certain other administrative services pertaining to the Plan. Premera does not insure the benefits described in this Section.

QUICK REFERENCE BOX

- MEMBER SERVICES AND CLAIM INQUIRIES, USE THE CUSTOMER SERVICE NUMBER ON THE BACK OF YOUR ID CARD OR CALL **1-866-358-2300**;
- HRA CLAIMS ONLINE SUBMISSION:
  ACCESS WWW.PREMERA.COM/T-MOBILE AND CLICK ON MANAGE YOUR ACCOUNT
- ONLINE ASSISTANCE: WWW.PREMERA.COM/T-MOBILE

A Health Reimbursement Account is a financial account that allows T-Mobile USA, Inc. to reimburse you for "qualified" health expenses paid by you, under the associated medical plan, to offset health care costs.

The HRA maximizes the value of your health care dollars and allows you to become more engaged in managing health care spending. Premera offers several tools to help you make more informed health care decisions and manage your HRA account balance. Once you spend your entire HRA balance, you are responsible for paying expenses as described in this SPD.

YOU CAN KEEP TRACK OF THE FUNDS IN YOUR HRA BY GOING ONLINE TO WWW.PREMERA.COM/T-MOBILE, BY CALLING THE TOLL-FREE NUMBER ON THE BACK OF YOUR PREMERA ID CARD.

Please read this Section thoroughly to learn how the HRA component of the Plan works. If you have questions call the number on the back of your Premera ID card.

What is a Health Reimbursement Account?

Health Reimbursement Accounts are "unfunded" accounts; otherwise known as a demand deposit account. T-Mobile USA, Inc. is not required to prepay into it, instead, funds allocated to the HRA are made available to reimburse you for claims as they occur. All contributions allocated to your HRA are owned, controlled and payable solely from the general assets of T-Mobile USA, Inc. You are not permitted to make any contribution to the HRA, whether made on a pre-tax or after-tax basis. In addition:

- The HRA is established by T-Mobile USA, Inc. and administered by Optum Financial in accordance with applicable provisions of the Internal Revenue Service Code and associated guidance issued by the IRS/Treasury Department;
- T-Mobile USA, Inc. determines which Internal Revenue Code 213(d) health expenses will be eligible for reimbursement through the HRA;
- Reimbursements of qualified medical expenses are tax-deductible for T-Mobile USA, Inc.;
- There is no limit to the contributions T-Mobile USA, Inc. can choose to allocate to your account;
- Employer contributions allocated to your HRA can be excluded from your gross income; and
- T-Mobile USA, Inc. will decide how to handle unused funds at the end of the calendar Plan year. Unused funds are not eligible for transfer outside of T-Mobile USA, Inc. accounts if your employment with T-Mobile USA, Inc. ends.

Who Is Eligible for the HRA And How To Enroll?

You must be covered under a medical plan sponsored by T-Mobile USA, Inc. and administered by Premera in order to participate in the HRA. You are enrolled in the HRA at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to participate in the Plan is described in this Summary Plan Document. Each year during Open Enrollment, you have the opportunity to review and change your benefit election. Any changes you make during Open Enrollment will become effective as described in this Summary Plan Document.

Cost of Coverage

You and T-Mobile USA, Inc. share in the cost of the medical plan. There is no additional charge to you for participation in the HRA component of your medical plan. Your contribution amount (also known as a premium) depends on the medical plan you select and the family members you choose to enroll.

Your medical plan premium is deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld — and in most states, before state and local taxes are withheld. For more information on the Cost of Coverage please refer to this document under the heading *Cost of Coverage.*

Changing Your HRA Coverage

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period, coverage will become effective as described in this Summary Plan Document under the heading *Qualifying Family Status Change Events*.

For detail on the employer contribution to your HRA for mid-year enrollment and/or status changes see this Section — *Health Reimbursement Account* under heading How the HRA Works and look for "New Hires and Adjustments for Status Changes".

For information on ending your coverage please refer to this Section — *Health Reimbursement Account* under the heading *Termination of Coverage*.

How the HRA Works

How Much Money is Allocated to Your HRA — Employer Contributions

T-Mobile USA, Inc. will allocate a specified amount of funds to your HRA on a calendar Plan year basis specific to the coverage category you enroll in. The full amount is funded on your first day of coverage. For each claim presented to the HRA, available funds will be used to pay for your HRA Eligible Expenses. The table below contains the details for the employer contribution to your HRA:

Coverage Category	Annual Employer Contribution to HRA (please see notes below for pro-ration rules)
Employee	$500
Employee plus Spouse	$1,000
Employee plus Child(ren)	$1,000
Family	$1,000

New Hires and Adjustments for Status Changes

New Hires

If you are hired during the Plan year or are enrolling in the Plan during a special enrollment period as a result of a change in status, the amount of the Employer contribution allocated to your HRA may be prorated.

The above contributions are prorated to $41.66 per month for Employee only coverage or $83.33 per month of coverage for all other coverages. The entire amount is available in your account on day 1 of enrollment.

Example 1: Employee's coverage is effective on October 1 and employee enrolls in Employee coverage category. An amount equal to $124.98 ($41.66 times 3) will be credited to employee's HRA account on October 1.

Example 2: Employee's coverage is effective on October 28 and employee enrolls in Employee coverage category. An amount equal to $124.98 ($41.66 times 3) will be credited to employee's HRA account on October 28.

Status Changes

When you switch among coverage categories T-Mobile USA, Inc.'s contribution amount allocated to your HRA may increase or decrease by category.

Under the Plan, if you increase your category (e.g., self to self plus family) the employer contribution to your HRA will be adjusted to your new category for those remaining months of the Plan year. If you decrease your category (e.g., you change from self plus family to self) the employer contribution to your HRA will not be adjusted and will remain at the same level prior to your new category for the remaining months of the Plan year.

Example 1: Employee enrolls in employee only coverage on the HRA plan effective January 1. T-Mobile funds $500 to the HRA on January 1. The employee adds a spouse to the plan effective September 1. T-Mobile will fund an additional $166.64 to the HRA for employee and spouse coverage (pro-rated funding for the higher category for September, October, November and December).

Example 2: Employee enrolls in family coverage on the HRA plan effective January 1. T-Mobile funds $1,000 to the HRA on January 1. The employee removes their spouse and child from the plan effective October 1. No adjustments will be made to remove any funding; funds will remain as though there was no change.

Reinstatement of former participant: Subject to the Special Rules noted above, if you terminate employment or cease to be an Eligible Employee and are rehired or return to status as an Eligible Employee during the same Plan Year in which you terminated or ceased to be eligible, and the rehire or return to status occurs within 30 days of the termination or cessation, you are required to participate for the remainder of the Plan Year by continuing your original election for that Plan Year on a pro rata basis. If you are rehired within 30 days in a different Plan Year, a new enrollment opportunity is provided. The effective date of coverage is the first of the month following date of rehire. If more than 30 days pass (but less than 13 weeks pass) and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following date of rehire. If 13 weeks or more pass, and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following 30 days of continuous employment after date of rehire.

You can keep track of the funds in your HRA by going online to www.premera.com/t-mobile.

What Type of Medical Expenses Qualify for Reimbursement from the HRA

Not all health-related expenses qualify for reimbursement under the HRA Plan. Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time defines what health care expenses are considered "qualified" medical expenses for federal income tax purposes. Only amounts that are paid specifically to reimburse eligible medical care expenses, as defined in Section 213(d), will be covered under the HRA Plan. T-Mobile has determined which of those "qualified" medical expenses will be considered HRA Eligible Expenses under your Plan and reimbursable from your HRA.

Under your Plan, the HRA reimburses all amounts due from claims for medical expenses that are eligible from the underlying medical plan, plus any claims for pharmacy expenses. Allowable expenses include Annual Deductible, Coinsurance and Copayments.

What Happens to Remaining Balances in Your HRA

If you don't spend all the funds in your HRA during the initial calendar Plan year, and you re-enroll in the Plan for the following year, any remaining HRA balance rolls over into your account for the next calendar Plan year. In this manner your HRA may "grow" almost like a savings account. The total amount that rolls over is limited to $6,000, any funds over this amount are forfeited.

If you don't re-enroll in the Plan for the following year, you forfeit any unused funds remaining in the account.

HRA Account Balance Transfers

T-Mobile USA, Inc. may allow for balance transfers in cases where both spouses are T-Mobile USA, Inc. employees and one spouse terminates their employment with T-Mobile USA, Inc. Upon request, balance transfers will be granted from one employee spouse to another, remaining, employee spouse upon termination. This transfer will be contingent on the terminating spouse waiving HRA COBRA rights.

Upon death of an active T-Mobile, USA, Inc. employee balance transfers and continuance of reimbursement of expenses to dependent spouse and children will be permitted. The HRA is subject to COBRA as detailed in this Plan Document. Upon a COBRA-qualifying event — such as death of the employee — spouses and children, as independent qualified beneficiaries, may elect to continue the same coverage that was in effect on the date of the event with the HRA funds balance.

Balance transfers will not be permitted to cash or taxable benefit upon the death, termination, or other cessation of coverage under the HRA.

Health Care Spending Payment Card

The Health Care Spending Payment Card is a payment mechanism that allows members a means for direct payment of HRA Eligible Expenses, per your specific plan design, to Premera network providers, Drugstore.com, Walgreen's and participating merchants. Payment for HRA Eligible Expenses will come directly from your HRA and eliminates the need for you to submit most paper claims.

You will be provided with one Health Care Spending Payment Card, with terms and conditions and activation information that may be used at certain locations where major credit cards are accepted.

Use of the Health Care Spending Payment Card is voluntary. The card must be activated prior to use. To activate the Health Care Spending Payment Card, you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate or go to www.premera.com/t-mobile. Once activated you can use your card immediately as long as it is after the plan effective date.

You can also be reimbursed for HRA Eligible Expenses by going to www.premera.com/t-mobile.

The Internal Revenue Service may require that you provide a receipt, statement, or Explanation of Benefits for certain HRA Eligible Expenses that have already been reimbursed through your card in order to prove that the services received were for qualified medical expenses incurred within the plan year, as defined by T-Mobile USA, Inc. in this SPD. You will be notified through a letter if you need to provide such information. If Optum Financial does not receive the required documents as described in the letter, your card will be suspended in accordance with applicable IRS regulations and guidelines. If Optum Financial determines that the claim was not for a qualified medical expense as described in the letter this will be considered an overpayment to you and Optum Financial will automatically withhold the payment of future claims until the full amount of the overpayment is received. Upon receipt of proper documentation or repayment your card will be reactivated.

Premera Network Providers and Participating Merchants

The consumer website, www.premera.com/t-mobile, contains a directory of medical providers in Premera's provider network. While network status may change from time to time, www.premera.com/t-mobile has the most current source of provider network information. Use www.premera.com/t-mobile to search for network providers available in your specific plan design.

Participating drug store and pharmacy merchants comply with specific methods used to identify and substantiate eligible expenses, per the United States Internal Revenue Code of 1986 (“IRC”), as amended from time to time. You can see a full list of participating merchants at http://www.sig-is.org. Participating merchants identify what is an eligible expense under 213d of the IRC, they do not identify eligible HRA expenses at point of sale based on your specific plan design.

Using the Health Care Spending Payment Card

In order to use the Health Care Spending Payment Card, you will need to enter ‘credit’ on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your HRA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the Health Care Spending Payment Card because certain payments must be verified and Optum Financial may request this receipt from you to ensure that payment was made for an HRA Eligible Expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Payment Card through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design. A claim number is assigned to the transaction.

Qualified Locations and Providers

The Premera health care payment card may not be used at point of sale to make a purchase from non-participating merchants. You will need to pay using another form of payment, and then submit eligible expense receipts for reimbursement as described under the Section — *Requesting Reimbursement from your HRA*.

The Premera health care payment card may be used for a point-of-sale purchase at any Premera network provider or participating merchant with a Point-of-Service (POS) bankcard terminal that accepts Visa/MasterCard® such as a network hospital, network physician and retail network pharmacy counters.

You may choose to use your Premera health care payment card for mail order prescriptions by going to an online pharmacy at Drugstore.com via www.premera.com/t-mobile. Additionally, your Health Care Spending Payment Card can be used at participating drug store and pharmacy merchants.

Partial Payment Authorization

Partial authorization capability allows you to use your Premera health care payment card with transactions amounts greater than the funds available in your HRA for a portion of the transaction at merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HRA, the HRA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment.

NOTE: *Not all merchants accept partial authorization.*

Network Benefits

In general, if you receive covered services from a Network provider, Premera will process the payment for the medical plans portion of the cost of the Covered Health Services and send it directly to the Physician or facility.

Funds allocated to your HRA will be available to help you pay a portion of your out-of-pocket costs under the medical plan as described in this document in Section — *How the HRA Works*.

Non-Network Benefits

If you receive a bill for a covered service, you (or the provider if they prefer) must send the bill to Premera for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to Premera at the address on the back of your Premera ID card.

If you receive Covered Health Services from a Non-Network provider, use your HRA payment card to pay or submit a manual reimbursement request at www.premera.com/T-Mobile.

Prescription Drug Benefit Claims

How Will You Be Reimbursed For Pharmacy Expenses?

When you visit a pharmacy use your HRA payment card or keep it on file with your mail order pharmacy. There will be no out-of-pocket expense for you until you spend your entire HRA balance. Once you do spend down the balance in your HRA you will need to pay the pharmacy at the point of sale. You are responsible for paying expenses as described in this Summary Plan Document.

How to File Your Claim for Reimbursement from the HRA

To be reimbursed from your HRA please visit www.premera.com/T-Mobile or the Optum Financial mobile app and follow appropriate prompts for initial set-up.

IMPORTANT

YOU CAN VIEW EOB'S AND YOUR HRA ACCOUNT ONLINE VIA WWW.PREMERA.COM/T-MOBILE. THIS SITE INCLUDES MANY FEATURES SUCH AS THE OPTION TO:

- VIEW YOUR HRA SUMMARY PAGE DETAILING CONTRIBUTIONS AND AMOUNT LEFT IN YOUR HRA;
- VIEW YOUR HRA CLAIMS SUMMARY INCLUDING CLAIM TRANSACTION DETAILS.

Requesting Reimbursement from Your HRA

If you have allocated funds available in your HRA you may submit a claim for reimbursement for the HRA Eligible Expenses from your HRA. If you do submit a request for reimbursement for Network claims, the request must be received no later than 365 days following the end of the Plan year in which you are eligible under this Plan. If you don't provide this information to Optum Financial within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA.

You cannot be reimbursed for any expense paid under your medical plan, and any expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

IMPORTANT NOTE

THE DATE ON WHICH YOU INCURRED AN ELIGIBLE MEDICAL EXPENSE IS USED WHEN DEDUCTING AMOUNTS FROM YOUR HRA. THIS ALLOWS YOUR HRA TO ACT LIKE A SAVINGS ACCOUNT, AVAILABLE FOR YOUR USE WHEN YOUR CLAIM IS PAID.

HRA Coordination of Benefits (COB)

For information on how your Benefits under this Plan coordinate with other medical plans and how coverage is affected if you become eligible for Medicare, refer to Section — *Coordination of Benefits (COB)*.

Overpayment and Underpayment of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan. For further information on COB refer to Section — *Coordination of Benefits (COB)*.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement, as defined in this SPD Section — *Subrogation and Reimbursement*.

When HRA Coverage Ends

Your coverage under the Plan ends as described in this document, Section — *Termination of Coverage*.

Continuation of Coverage — Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Reimbursement Account. See "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

COBRA continuation coverage will be offered with respect to your HRA. If your employment terminates for any reason the funds in your HRA will revert back to T-Mobile after your claim run-out period, unless you elect COBRA coverage as described in this document, Continuation of Health Coverage (COBRA). If you elect COBRA coverage, HRA funds will remain available to assist you in paying your out-of-pocket costs under the medical plan while COBRA coverage is in effect. The HRA balances under COBRA are recalculated using the methods elected by T-Mobile USA, Inc. for mid-year enrollment and/or status changes; as described in Section — *Health Reimbursement Account* under heading *How the HRA Works* and look for "New Hires and Adjustments for Status Changes".

HRA Glossary

Many of the terms used throughout this section may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how benefits are paid. This Section defines terms used throughout this section, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this Section have the meaning set forth in this Summary Plan Document.

HRA — Health Reimbursement Account or HRA. It is an Internal Revenue Code Section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA Eligible Expense — a health care expense that you incur on or after the date you are enrolled in the HRA Plan and include the following: (i) an eligible medical expense as defined in Section 213(d); (ii) that is an Eligible Expense as defined in this document, including Prescription Drugs (iii) a medical expense not paid for under your active medical Plan as it represents your portion of responsibility for the cost of health care such as Annual Deductible, coinsurance (percentage of medical expense that you pay) and copayments; and (iv) a medical expense not reimbursable through any other plan covering health benefits, other insurance, or any other accident or health plan.

HRA Plan — The Health Reimbursement Account portion of the Health Reimbursement Account (HRA) Plan.

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how this plan is administered. It also includes information about federal and state requirements we and the Group must follow and other information that must be provided.

Conformity With The Law

If any provision of the plan or any amendment thereto is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Evidence Of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before benefits under this plan are provided. This proof may be submitted by you, or on your behalf by your health care providers. No benefits will be available if the proof isn't provided or acceptable to the plan.

Healthcare Providers — Independent Contractors

All healthcare providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this plan or the contract between Premera and the Group are intended to create, nor shall they be deemed or construed to create any employment or agency relationship between us and the provider of service other than that of independent contractors.

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to a member's or provider's commission of fraud or providing any intentionally false or misleading statements, the plan is entitled to recover these amounts. See the ***Right Of Recovery*** provision later in this section.

And, if a member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the member's acceptability for coverage, we may, as directed by the Group:

- Deny the member's claim
- Reduce the amount of benefits provided for the member's claim
- Void the member's coverage under this plan (void means to cancel coverage back to its effective date, as if it had never existed at all)

NOTE: *We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.*

Member Cooperation

You're under a duty to cooperate with us and the Group in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and the Group in the event of a lawsuit.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable.) In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours as applicable.)

Notice Of Information Use And Disclosure

We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used, or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims (genetic information is not collected or used for underwriting or enrollment purposes)
- Coordinating benefits with other health care plans
- Conducting care management or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with the Group

This information may also be collected, used, or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you, or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our customer service department and ask a representative to mail a request form to you.

Notice Of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which the plan provides benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

Notices

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if it's mailed to the Group or subscriber at the most recent address appearing on our records. We'll use the date of postmark in determining the date of

our notification. If you are required to submit notice to us, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

Right Of Recovery

On behalf of the plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, the plan won't honor any attempted assignment, garnishment, or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments, or any other rights of this plan.

At our option only, we have the right to direct the benefits of this plan to:

- The subscriber
- A provider
- Another health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies the plan's obligation as to payment of benefits.

Venue

All suits or legal proceedings brought against us, the plan, or the Group by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date the rights or benefits claimed under this plan were denied in writing, or of the completion date of the independent review process if applicable; and
- In the state of Washington or the state where you reside or are employed.

All suits or legal or arbitration proceedings brought by the plan will be filed within the appropriate statutory period of limitation, and you agree that venue, at the plan's option, will be in King County, the state of Washington.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. See ***Covered Services***.

HOW DO I FILE A CLAIM?

Claims Other Than Prescription Drug Claims

Many providers will submit their bills to us directly. However, if you need to submit a claim, follow these simple steps:

Step 1

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling customer service.

Step 2

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address, and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or diagnosis code from the most current edition of the **International Classification of Diseases** manual
- Procedure codes from the most current edition of the **Current Procedural Terminology** manual, the **Healthcare Common Procedure Coding** manual, or the **American Dental Association Current Dental Terminology** manual for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an injury, the date, time, location, and a brief description of the event

Step 3

If you're also covered by Medicare, and Medicare is primary, you must attach a copy of the "Explanation of Medicare Benefits."

Step 4

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

Mail your claims to:

Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

Timely Filing

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies
- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

The plan won't provide benefits for claims we receive after the later of these 2 dates except when required by law.

Special Notice About Claims Procedure

We'll make every effort to process your claims as quickly as possible. We process claims in the order in which we receive them. We'll tell you if this plan won't cover all or part of the claim no later than 30 days after we first receive it. This notice will be in writing. We can extend the time limit by up to 15 days if it's decided that more time is needed due to matters beyond our control. We'll let you know before the 30-day time limit ends if we need more time. If we need more information from you or your provider in order to decide your claim, we'll ask for that information in our notice and allow you or your provider at

least 45 days to send us the information. In such cases, the time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information we need, we have 15 days to give you our decision.

- If your claim was denied, in whole or in part, our written notice (see ***Notices***) will include:
- The reasons for the denial and a reference to the provisions of this plan on which it's based
- A description of any additional information needed to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of the plan's complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter stating these reasons.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, or a friend or relative. You must notify us in writing and give us the name, address, and telephone number where your appointee can be reached.

If all you have to pay is a copay for a covered service or supply, your payment of the copay to your provider is not considered a claim for benefits. You can call customer service to get a paper copy of your explanation of benefits for the service or supply. The phone number is on your Premera ID card. Or you can visit our website for secure online access to your claims. If your claim is denied in whole or in part, you may send us a complaint or appeal as outlined under ***Complaints And Appeals***.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in this plan, you may file suit in a state or federal court.

COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with Premera.

What is a Complaint?

Other than denial of payment for medical services or non-provision of medical services, a complaint is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with Premera.

Call customer service at:
866-358-2300 (TTY:711)

Send a fax to:
425-918-5592

Send the details in writing to:
Premera Blue Cross
PO Box 91102
Seattle, WA 98111-9202

How to file a complaint

For complaints received in writing, we will send a written response within 30 days.

What is an Appeal?

An appeal is a request to review a specific decision or an adverse benefit determination Premera has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member’s or applicant’s eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision

- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protection against balance billing as defined by federal and state law.

What You Can Appeal

Claims and Prior Authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device, or prescription was denied or partially denied. This includes prior authorization denials.

Appeal Levels

You have the right to two levels of appeals:

Appeal Level	What it Means	Deadline to Appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2 (Internal)	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified of our Level 1 appeal decision.
External	If we deny your Level 2 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	Four months from the date you were notified of our Level 2 appeal decision. OR Four months from the date the response to your Level 1 appeal was due if you did not get a response or it was late.

How to Submit an Appeal In Writing

Step 1. **Get the Form**	Complete the **Member Appeal Form**, you can find it on www.premera.com/t-mobile or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 866-358-2300 (TTY:711)
Step 2. **Collect Supporting Documents**	Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on www.premera.com/t-mobile. We can't release your information without this form.

Step 3. **Send in My Appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 OR **Fax to**: 425-918-5592

NOTE: *You may also call customer service to verbally submit an appeal.*

If you would like to review the information used for your appeal, send us a request in writing to:

Premera Blue Cross
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

Fax: (425) 918-5592

Appeal Response Time Limits

We'll review your appeal and send a decision in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, Premera representatives who have not reviewed the case before will review and make a decision. Medical review denials will be reviewed by a medical specialist.

Type of Appeal	When to Expect a Response
Urgent Appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing
Pre-Service Appeals (a decision made by us before you received services)	Within 15 days
All Other Appeals	15-30 days
External Appeals	■ Urgent appeals within 72 hours ■ Other IRO appeals within 45 days after the IRO gets the information

What If We Need More Time

Except for urgent appeals, we can extend the time limits. We will notify you, if for good cause, more time is needed. An extension cannot delay the decision beyond 30 days without your informed written consent.

What if You Have Ongoing Care

Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, inpatient care and rehabilitation.

If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, the plan will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved. If our decision is upheld, you must repay all amounts the plan paid for ongoing care during the appeal review.

What If It's Urgent

If your condition is urgent, you will get our response sooner. Urgent appeals are only available for services you are currently receiving or have not yet received.

Examples of urgent situations are:

- Your life or health is in serious danger, or a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professional or your treating physician
- You are requesting coverage for inpatient or emergency services that you are currently receiving

If your situation is urgent, you may ask for an expedited external appeal at the same time you request an expedited internal appeal.

How to Ask for an External Review

External reviews will be done by an Independent Review Organization (IRO).

Step 1. **Get the Form**	**We'll tell you about your right to an external review with the written decision of your internal appeal.** Complete the Independent Review Organization (IRO) Request form, you can find it on www.premera.com/t-mobile or call customer service to request a copy. You may also write to us directly to ask for an external appeal.
Step 2. **Collect Supporting Documents**	Collect any supporting documents that may help with your external review. This may include medical records and other information. We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
Step 3. **Send in My External Review Request**	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 OR **Fax to:** 425-918-5592

External appeals are also available for decisions related to Premera's compliance with protections against balance billing in accordance with federal and state law.

Once The IRO Decides

For urgent appeals, the IRO will inform you and Premera immediately. Premera will accept the IRO decision on behalf of the plan.

If the IRO:

- Reverses our decision, we will apply their decision quickly.
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about a denial of a claim or your appeal rights, you may call customer service at the number listed on your Premera ID card.

You can also contact the Employee Benefits Security Administration of the U.S. Department of Labor. The phone number is 866-444-EBSA (3272).

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan.

Accidental Injury

Physical harm caused by a sudden, unexpected event at a certain time and place. Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

Adverse Benefit Determination

An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protection against balance billing as defined by federal and state law.

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Ambulatory Surgical Center

A healthcare facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated mainly for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Applied Behavioral Analysis (ABA)

The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

Autism Spectrum Disorders

Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, as amended or reissued from time to time.

Benefit

What this plan provides for a covered service. The benefits you get are subject to this plan's cost shares.

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on December 31 at midnight.

Clinical Trials

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by one of the following:

- An institutional review board that complies with federal standards for protecting human research subjects and
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
  - The United States Department of Defense
  - The United States Department of Veterans' Affairs
  - A nongovernmental research entity abiding by current National Institute of Health guidelines

Community Mental Health Agency

An agency that's licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.

Complication of Pregnancy

A medical condition related to pregnancy or childbirth that falls into one of these three categories:

- A condition of the fetus that needs surgery while still in the womb (in utero)
- A condition the mother has that is caused by the pregnancy. It is more difficult to treat because of the pregnancy. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix that requires treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma, such as uterine rupture before onset or during labor
  - Hemorrhage before or after delivery that requires medical or surgical treatment
  - Placental conditions that require surgical intervention
  - Preterm labor and monitoring
  - Toxemia
  - Gestational diabetes
  - Hyperemesis gravidarum
  - Spontaneous miscarriage or missed abortion
  - A disease the mother has during pregnancy that is not caused by the pregnancy. The disease is made worse by pregnancy.
- A complication of pregnancy needs services that are more than the usual maternity services. This includes care before, during, and after birth (normal or cesarean).

Congenital Anomaly

A marked difference from the normal structure of an infant's body part, that's present from birth and manifests during infancy.

Cosmetic Services

Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This also includes drugs, services or supplies to alter the appearance of your skin or hair.

Cost Share

The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.

Covered Service

A service, supply or drug that is eligible for benefits under the terms of this Plan.

Custodial Care

Any portion of a service, procedure or supply that is provided primarily:

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel

Detoxification

Active medical management of medical conditions due to substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance taken, repeated vital sign monitoring, and use of medication to manage intoxication or withdrawal. Observation without active medical management, or any service that is claimed to be detoxification but does not include active medical management, is not detoxification.

Doctor (also called "Physician")

A state-licensed:

- Doctor of Medicine and Surgery (MD)
- Doctor of Osteopathy (DO)

Effective Date

The date when your coverage under this plan begins.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the Group's health care plan. If a subscriber or dependent enrolls under the ***Special Enrollment*** provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

Emergency Medical Condition (also called "Emergency")

A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-emergency medical condition are minor cuts and scrapes.

Emergency Services

A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services given in an emergency department. Emergency services are also provided by a behavioral

health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health.

Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant woman in active labor, to perform the delivery.

Ambulance transport, as needed, in support of the services above.

Experimental/Investigational Services

A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board.
- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Explanation of Benefits

An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.

Facility (Medical Facility)

A hospital, skilled nursing facility, approved treatment facility for substance use disorder, state-approved institution for treatment of mental or psychiatric conditions, or hospice. Not all health care facilities are covered under this contract.

Group

The entity that sponsors this self-funded plan.

Health Care Benefit Managers

Health Care Benefit Managers (HCBM): A person or entity that specializes in managing certain services for a health carrier or employee benefits programs. An HCBM may also make determinations for utilization of benefits and prior authorization for health care services, drugs, and supplies. These include pharmacy, radiology, laboratory, and mental health benefit managers.

Home Health Agency

An organization that provides covered home health care services to a member.

Home Medical Equipment (HME)

Equipment ordered by a healthcare provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as "Durable Medical Equipment" or "DME".

Hospice

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill. Care is focused on comfort and not intended to cure or improve the medical or functional outcome of a patient's condition or to prepare the patient for outpatient care settings.

Hospital

A healthcare facility that meets all of these criteria:

- It operates legally as a hospital in the state where it is located.
- It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients.
- It has a staff of providers that provides or supervises the care.
- It has 24-hour nursing services provided by or supervised by registered nurses.

A facility is not considered a hospital if it operates mainly for any of the purposes below:

- As a rest home, nursing home, or convalescent home
- As a residential treatment center or health resort
- To provide hospice care for terminally ill patients
- To care for the elderly
- To treat substance use disorder or tuberculosis

Illness

A sickness, disease, or medical condition.

Injury

Physical harm caused by a sudden event at a specific time and place. It's independent of illness, except for infection of a cut or wound.

In-Network Provider

A provider that is in one of the networks stated in ***How Providers Affect Your Costs***.

Inpatient

Confined in a medical facility as an overnight bed patient.

Lifetime Maximum

The maximum amount that Premera will provide during your lifetime.

Long-term Care Facility

A nursing facility licensed under chapter 18.51 RCW, continuing care retirement community defined under RCW 70.38.025, or assisted living facility licensed under chapter 18.20 RCW.

Maternity Care

Health services you get during pregnancy (before, during, and after birth) or for any condition caused by pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.

Medically Necessary and Medical Necessity

Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness or injury or its symptoms. These services must:

- Agree with generally accepted standards of medical practice;
- Be clinically appropriate, in terms of type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease.

- Not be mostly for the convenience of the patient, physician, or other health care provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" and "Your")

A person covered under this plan as a subscriber or dependent.

Mental Health Condition

A condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This does not include conditions and treatments for substance use disorder.

Non-Contracted Provider

A provider is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

Non-Participating Provider

A provider that is not in one of the provider networks stated in ***How Providers Affect Your Costs*** or is not in any network of Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, or the local Blue Cross Blue Shield licensee.

Observation

Monitoring and evaluation at a Hospital or other facility in order to determine whether an inpatient stay is required.

Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Out-Of-Network Provider

A provider that is not in one of the provider networks stated in ***How Providers Affect Your Costs***.

Outpatient

Treatment received in a setting other than as inpatient in a medical facility.

Outpatient Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures
- It doesn't provide inpatient services or accommodations

Plan

The Group's self-funded plan is described in this Summary Plan Document.

Premiums

The monthly rates to be paid by the member that are set by the Group as a condition of the member's coverage under the plan.

Prescription Drugs

Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Prior Authorization

Prior authorization is a process that requires you or a provider to follow before a service is given to determine if the service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness. You must ask for prior authorization before the service is delivered.

See ***Prior Authorization*** for details.

Provider

A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

Board Certified Behavior Analysts (BCBAs) will be considered health care providers for the purposes of providing applied behavior analysis (ABA) therapy, as long as both of the following are true: 1) They're licensed when required by the State in which they practice, or, if the State does not license behavior analysts, are certified as such by the Behavior Analyst Certification Board, and 2) The services they furnish are consistent with state law and the scope of their license or board certification. Therapy assistants/behavioral technicians/paraprofessionals that do not meet the requirements above will also be covered providers under this plan when they provide ABA therapy and their services are supervised and billed by a BCBA or one of the following state-licensed provider types: psychiatrist, developmental pediatrician, pediatric neurologist, psychiatric nurse practitioner, advanced nurse practitioner, advanced registered nurse practitioner, occupational or speech therapist, psychologist, community mental health agency that is also state-certified to provide ABA therapy.

Psychiatric Condition

A condition listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**. This does not include conditions and treatments for substance abuse disorder.

Reconstructive Surgery

Is surgery:

- That restores features damaged as a result of injury or illness.
- To correct a congenital deformity or anomaly

Rehabilitation Therapy

Rehabilitation therapy services or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition.

Rehabilitation services include physical therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.

Services

Procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.

Service Area

The area in which we directly operate provider networks. This area is made up of the states of Washington (except Clark County) and Alaska

Skilled Nursing Care

Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Spouse

An individual who is legally married to the subscriber. An individual who is a domestic partner of the subscriber.

Subscriber

An enrolled employee of the Group. Coverage under this plan is established in the subscriber's name.

Substance Use Disorder Conditions

They are substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away, but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member-initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused. Originating site: Hospital, Rural health clinic, federally qualified health center, physician's or other health care providers office, community mental health center, skilled nursing facility, home or renal dialysis center, except an independent renal dialysis center.

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

We, Us and Our

Premera Blue Cross or Premera.

Prescription Drug Benefits (Premera Blue Cross, Surest, and UnitedHealthcare)

Benefits are payable for outpatient Prescription Drugs.

Certain Prescription Drugs require Prior Authorization.

Specialty Prescription Drugs must be dispensed by a participating specialty pharmacy in order to be covered. The phone number to locate a participating specialty pharmacy is 1-800-237-2767. The Covered Person must be covered under this Prescription Drug Benefit when the prescription is filled.

Health Reimbursement Account Plan (HRA) and Health Savings Account Plan (HSA) Only: Preventive Care Medications are medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance or Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.caremark.com or by calling CVS Health at the toll-free telephone number on your ID card.

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.

Network Pharmacy

When a Network Pharmacy is used, the Covered Person pays the Copayment. Copayment amounts are listed in the **Medical Benefits Summary**.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Copay
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.

The Copayment will vary depending upon whether the prescription drug is a Tier 1, Tier 2, or Tier 3 medication. Network Pharmacies dispense Generic Drugs whenever possible.

When a Generic becomes available for a Brand Name prescription drug, the tier placement of the Brand Name prescription drug may change, and therefore, your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug is assigned.

Non-Network Pharmacy

There is no coverage for Prescription Drugs dispensed at a Non-Network Pharmacy.

Mail Service Network Pharmacy

A mail service pharmacy option has been provided for convenience. If the mail service pharmacy is used, the Covered Person must pay the Copayment. See your Employer for the necessary information about how to use the mail service option or go to www.caremark.com or contact CVS Health at **1-844-757-0417**.

There is no coverage for Prescription Drugs dispensed by a Non-Network Mail Service Pharmacy.

The Copayment will vary depending upon whether the prescription drug is a Tier 1, Tier 2, or Tier 3 medication.

When a Generic becomes available for a Brand Name prescription drug, the tier placement of the Brand Name prescription drug may change, and therefore, your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug is assigned.

Prescription Drug List

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services. The Plan pays Benefits at different levels for tier-1, tier-2, and tier-3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL).

CVS Health's Pharmacy and Therapeutics (P&T) Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

When considering a Prescription Drug Product for tier placement, the P&T Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

If an excluded drug is prescribed for a specific medical condition and you have attempted to use at least one alternative drug that's deemed as a therapeutic equivalent drug, you may qualify for an exception. If there are multiple covered alternatives you will likely need to try other covered alternatives unless there is a true medical reason why you cannot take the covered products. To request an exception, your prescriber can reach out to CVS Health stating your name and ID number as shown on your ID card, the Physician's name, the medical condition that requires the non-covered drug, the therapeutic equivalent drug that you attempted to use as an alternative drug and the length of projected use of the excluded drug. If your request is approved, you will receive a letter notifying you of the length of time your exception is approved, and you will be able to purchase your Prescription Drug at your local Network Pharmacy or by mail order by paying the applicable copay or coinsurance amount. Depending on the medication and CVS Health's review, the period of time you will be allowed for your medication exception will vary. For further information on how to file an appeal, please write to CVS/Caremark, Inc. Prescription Claim Appeals, MC109, P.O. Box 82084, Phoenix, AZ 85072-2084. You can also fax your appeal to **1-866-443-1172**.

NOTE: CVS Health *may periodically change the placement of a Prescription Drug Product among the tiers or exclude them from benefit coverage. These changes may occur without prior notice to you. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you should visit www.caremark.com or call CVS Health at the toll-free number on your ID card for the most current information.*

Supply Limits

Retail Pharmacy

If the Prescription Drug is dispensed by a retail Pharmacy, the following limits apply:

- Up to a 30-day supply or 90-day supply of a maintenance medication of a Prescription Drug unless adjusted based on the drug manufacturer's packaging size. Some products may be subject to additional supply limits adopted by CVS Health. A list of current additional supply limits may be obtained from CVS Health.
- A one-cycle supply of an oral contraceptive. Up to three cycles can be purchased at one time if a Copayment is paid for each cycle supplied.

Mail Service Pharmacy

If the Prescription Drug is dispensed by a mail service pharmacy, the supply limit is up to a 90-day supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size or any additional supply limits adopted by CVS Health. A list of current supply limits may be obtained from CVS Health.

Preventive Medications as Required by the Patient Protection and Affordable Care Act

The following are examples of medications (prescription required) that are dispensed at a network pharmacy are covered subject to no copay but with the following limits (for a complete list please visit www.caremark.com):

- Low-dose aspirin for women at risk for preeclampsia during pregnancy;
- Fluoride supplements for Covered Persons who are 5 years of age or younger.
- Folic acid supplements for women;
- Certain contraceptive methods (pharmaceutical and medical) are available to you free of charge when obtained at a Network Pharmacy; and
- HIV prevention drugs.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician or Prescriber, or you to obtain prior authorization from CVS Health. CVS Health will determine if the Prescription Drug, in accordance with CVS's approved guidelines, is both:

- A Covered Health Service as defined by the Plan in this document; and
- Not Experimental or Investigational or Unproven Service, as defined in ***Medical Plan Glossary***.

The Plan may also require you to obtain prior authorization from CVS Health so CVS Health can determine whether the Prescription Drug Product meets criteria for appropriate use in accordance with its approved guidelines.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider or you are responsible for obtaining prior authorization from CVS Health (**1-844-449-8734**).

Limitation on Selection of Pharmacies

If it is determined that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, a single Network Pharmacy may be selected for you.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.caremark.com or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to CVS Health's periodic review and modification.

NOTE: *Some products are subject to additional supply limits based on criteria that the Plan Administrator and CVS Health have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.*

Identification Card

If a Covered Person does not show the identification card at the time Prescription Drugs are obtained, the Covered Person will be required to pay the full cost of the Prescription Drug and seek payment from CVS Health.

Additional Information about Prescription Drugs

Brand Name Drug

Brand Drug means an FDA approved, or a drug that is dispensed by FDA a DESI (Drug Efficacy Study Implementation) drug or product. For avoidance of doubt, Brand Drugs may include, but are not limited to drugs, vaccines, supplies, medical devices, kits, diabetic supplies, OTCs, and test strips.

Generic Drug

Generic Drug or Product means and FDA approved drug, or drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product that is therapeutically equivalent to other pharmaceutically equivalent products. For avoidance of doubt, Generic Drugs may include, but are not limited to drugs, vaccines, supplies, medical devices, kits, diabetic supplies, OTCs, and test strips.

Network Pharmacy

Network/Participating Pharmacy means a retail pharmacy that participates in a retail network established by CVS Caremark. A Network Pharmacy can be either retail or a mail service pharmacy.

Prescription Drug Charge

The rate the Plan has agreed to pay CVS Health on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Order or Refill

The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Prior Authorization

The process of obtaining approval for certain Prescription Drugs, prior to dispensing, using guidelines approved by CVS Health. This approval is to be obtained from CVS Health by the prescriber or physician. The list of Prescription Drugs requiring Prior Authorization is subject to periodic review and modification by CVS Health.

Specialty Prescription Drug

Specialty Drugs are defined as certain pharmaceuticals, biotech, or biological drugs, that are used in the management of complex or genetic diseases. You may access a complete list of Specialty Prescription Drugs via the internet at www.caremark.com or by calling CVS Health Specialty at **1-800-237-2767**.

Not Covered

- Drugs given while confined in a Hospital, nursing home or similar place that has its own drug dispensary;
- Therapeutic devices or appliances, including colostomy supplies and support garments, regardless of intended use. (this exclusion does not apply to insulin delivery devices or products used for diabetic testing, e.g. insulin syringes/needles, pumps, blood glucose testing strips, etc.);
- Multivitamins and Nutritional supplements. (This exclusion does not apply to prenatal vitamins, vitamins with fluoride and single entity vitamins that have indications for treating specific diseases, e.g. B-12 injections);
- Drugs dispensed in any amount that exceed the supply limits;
- Certain unit dose packaging or repackages of Prescription Drug Products;
- Drugs for erectile dysfunction and hair loss;
- Drugs available over the counter that do not require a Prescription Order or Refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug;

- Specialty Prescription Drugs that are not dispensed through a participating specialty pharmacy;
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill;
- Compounded drugs that contain a non-FDA approved bulk chemical;
- Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product; and
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, T-Mobile has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the Plan's specialty drug list are included in the program and will be subject to a 30% coinsurance. However, if a member enrolls in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications — in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you choose to opt out of the program, you must call 1-800-578-4403. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. Eligible members who choose to decline enrollment in an available manufacturer copay assistance program will be responsible for the full amount of the 30% coinsurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

Company's Right to Distributions. To the fullest extent permitted by ERISA and other applicable law, any payment or distribution from insurance companies, third party administrators or other service providers, including rebates, refunds, discounts, dividends, retroactive rate adjustments or other refunds shall be the property of T-Mobile and will be retained by T-Mobile. Any such payments that are treated as "plan assets" will be used to pay benefits or reasonable plan expenses.

Annual Notices

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

MEDICAL COVERAGE PATIENT PROTECTIONS

If a medical benefit option under the Plan requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If the medical plan option designates a primary care provider automatically, the Plan will designate one for you until you make a designation. For information on how to select a primary care provider, and how to obtain a list of the participating primary care providers, please refer to the applicable certificate of coverage or Summary Plan Description.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the benefit networks who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. You can locate health care professionals who specialize in obstetrics or gynecology by referring to the applicable certificate of coverage or Summary Plan Description.

MASTECTOMY BENEFITS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility:

ALABAMA — Medicaid	ALASKA — Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS — Medicaid	**CALIFORNIA — Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA — Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA — Medicaid	**INDIANA — Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA — Medicaid and CHIP (Hawki)	**KANSAS — Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY — Medicaid	**LOUISIANA — Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE — Medicaid	**MASSACHUSETTS — Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA — Medicaid	MISSOURI — Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA — Medicaid	**NEBRASKA — Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA — Medicaid	**NEW HAMPSHIRE — Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY — Medicaid and CHIP	**NEW YORK — Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA — Medicaid	**NORTH DAKOTA — Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA — Medicaid and CHIP	**OREGON — Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA — Medicaid and CHIP	**RHODE ISLAND — Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 Children's Health Insurance Program (pa.gov) Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA — Medicaid	**SOUTH DAKOTA — Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS — Medicaid	UTAH — Medicaid and CHIP
Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT — Medicaid	**VIRGINIA — Medicaid and CHIP**
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON — Medicaid	**WEST VIRGINIA — Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-Free Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN — Medicaid and CHIP	**WYOMING — Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)	**Centers for Medicare & Medicaid Services** www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Mental Health and Wellbeing Program — LiveMagenta (Lyra Health, Grokker & MySecureAdvantage)

Mental Health and Wellbeing Solutions through Lyra Health are available to all employees and their household members, regardless of whether you are enrolled in a T-Mobile medical plan with Premera Blue Cross (Premera), Surest, or UnitedHealthcare (UHC). Coverage begins automatically on your first day of employment or the date a dependent becomes eligible. Household members include anyone living in your home who shares in your daily life — such as a spouse or domestic partner, children, or other loved ones residing in your household.

Confidential help available **1-855-780-5958** **or** **https://livemagenta.com**	■ Assessment and Counseling — For employees and their household members, up to ten Lyra care sessions per issue per year are available at no cost for emotional wellbeing, stress, relationship challenges, family concerns, or substance use. Members complete a short online assessment for real-time provider matching and scheduling (no access code required). ■ Therapy and Coaching — Evidence-based sessions with licensed clinicians and certified coaches, available virtually or in person, often within one day. ■ Family, Child, and Teen Support — Therapy and coaching for parents, couples, children, and teens to strengthen relationships and resilience. ■ Lyra Renew – Substance Use Recovery — Confidential, voluntary support for employees or dependents addressing alcohol or drug use, including therapy, recovery groups, and medication management if needed. ■ Smoking and Nicotine Cessation — Access to quit-coaching, text support, and nicotine replacement guidance through Lyra's Quitline and integrated digital programs. ■ Mental Health Evaluations — Licensed clinicians provide timely, comprehensive evaluations to support leave of absence, short-term disability, or return-to-work determinations in coordination with T-Mobile's LOA and benefits teams. ■ Dialectical Behavioral Therapy (DBT) for Complex Needs — Intensive, evidence-based treatment for high-acuity mental health conditions such as emotional dysregulation, trauma, or self-harm. ■ Complex Care Navigation — Support for members with severe or chronic mental health needs, including coordination with inpatient, residential, and higher-level care programs. ■ Work-Life and Financial Wellbeing — Continued access to MySecureAdvantage (MSA) for financial coaching, debt management, savings, and retirement planning. ■ Wellbeing Resources — Access to Grokker, T-Mobile's digital wellbeing platform offering fitness, nutrition, mindfulness, and sleep video content to support whole-person health. ■ Legal and Identity Theft Assistance — Consultation and document review with licensed attorneys, plus identity theft and fraud-resolution services. ■ Caregiver and Elder Support — Resources and guidance for adult and elder care, including transportation, housing, and chronic illness support.

	■ Dedicated Resource Coordination — Personalized support to help employees and families find local community resources for food, housing, childcare, transportation, legal aid, and other essential needs. ■ Critical Incident and Crisis Response — 24/7 clinical support following workplace or personal crises, available to employees, leaders, and HR. ■ Leadership Consultation and Training — Dedicated 24/7 line for HR and SAFE teams, plus ongoing Notice & Respond and mental health training for people leaders. ■ Digital Tools and Self-Care — On-demand courses, mindfulness, and wellbeing tools through Lyra Essentials.

Nurse Line

24 Hour Nurseline — Premera Blue Cross (Premera)	
24-Hour Nurseline	■ 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 and with health problems. ■ You can reach the 24-hour Nurseline at **1-855-429-7236**. 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, advise 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.

Dental Plans (administered by Delta Dental of Washington)

DENTAL BENEFITS SUMMARY

Delta Dental of Washington (DDWA)	Maximums and Limits (Plan Year is January 1 through December 31)	PPO Network Dental Plan (09037)		Open Network Dental Plan (09034)		
		Delta Dental PPO Provider	Non-PPO Provider	Delta Dental PPO Provider	Delta Dental Premier Dentist	Non-Participating Dentist
Plan Year Deductible	Waived on Class I Benefits, Accidental Injury Benefits and Orthodontic Benefits	$50 per individual $150 per family	No coverage or benefits provided	$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	100%	No coverage or benefits provided	100%	100%	100%
Class II Benefits	**Restorative:** Fillings, oral surgery, root canals, periodontics	80%	No coverage or benefits provided	80%	80%	80%
Class III Benefits	**Major:** Crowns, dentures, bridges, partials, implants, occlusal guard (night guard) (covered at 50% every 3 years)	50%	No coverage or benefits provided	50%	50%	50%
Accidental Injury Benefits	Subject to plan year maximum (deductible waived)	100%	No coverage or benefits provided	100%	100%	100%
Plan Year Maximum	Per covered individual	$2,000	No coverage or benefits provided	$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	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	50%	50%	50%

HOW TO USE YOUR PROGRAM

The best way to take full advantage of your dental Plan is to understand its features. You can do this most easily by reading this document before you go to the dentist. This document is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this document does not answer all of your questions, or if you do not understand something, call a Delta Dental of Washington (DDWA) customer service representative at **1-206-522-2300** or **1-800-238-3107**. *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.*

CHOOSING A DENTIST

T-Mobile PPO Network Dental Plan

With DDWA, you may select any licensed and participating Delta Dental PPO dentist. Non-PPO dentists are only covered for orthodontic procedures; however, your orthodontic benefits may be paid at a higher level and your out-of-pocket orthodontic expenses may be lower if you choose a participating Delta Dental PPO orthodontist. Tell your dentist that you are covered by a DDWA Dental Plan and provide your identification number, the Plan name, and the group number.

Please note that PPO Network Dental Plan does not provide coverage for Class I, II, III, or TMJ services performed by a non-PPO Dentist. Orthodontic procedures covered by this Plan may be obtained from Delta Dental Premier Dentists (non-PPO).

T-Mobile Open Network Dental Plan

With DDWA, you may select any licensed dentist. However, your benefits may be paid at a higher level and your out-of-pocket expenses may be lower if you choose a Delta Dental dentist.

You are not limited to visiting a Delta Dental dentist. If you choose a nonparticipating dentist, you will be responsible for having the dentist complete and sign claim forms. It will also be up to you to ensure that the claims are sent to DDWA. Claim payments will be based on actual charges and may be paid to either the dentist, the member or both. Please be aware that DDWA has no control over nonparticipating dentists' charges or billing procedures.

CATEGORIES OF DENTISTS

For purposes of the T-Mobile dental plan, DDWA defines dentists in three categories.

Delta Dental PPO Dentists

If you select a dentist who is a Delta Dental PPO provider, that dentist has agreed to provide treatment for enrolled persons covered by DDWA plans. You will not have to hassle with sending in claim forms. Delta Dental PPO dentists complete claim forms and submit them directly to DDWA. Payment will be based on the pre-approved fees your dentist has filed with the local Delta Dental plan and will be sent directly to the dentist from DDWA. You will be responsible only for stated coinsurances, deductibles, any amount over the Plan maximum and for any elective care you choose to receive outside the covered dental benefits. You will not be charged more than the Delta Dental PPO dentist's approved fee or the fee that the Delta Dental PPO dentist has filed with us.

Please note that PPO Network Dental Plan does not provide coverage for Class I, II, III, or TMJ services performed by a non-PPO Dentist. Orthodontic procedures covered by this Plan may be obtained from Delta Dental Premier Dentists (non-PPO).

Delta Dental Premier® Dentists (non-PPO)

Delta Dental Premier® dentists also have contracts with Delta Dental, but they are not necessarily part of the PPO network. Delta Dental Premier dentists will submit claims for you and receive payment directly from DDWA. Their payments will be based on their pre-approved fees with Delta Dental. They also cannot charge you more than these fees. You will be responsible only for stated deductibles, coinsurance and/or amounts in excess of the program maximums. Please note that PPO Network Dental Plan does not provide coverage for Class I, II, III, or TMJ services performed by a non-PPO Dentist. Orthodontic procedures covered by this Plan may be obtained from Delta Dental Premier Dentists (non-PPO).

Non-Participating Dentists

Please note that PPO Network Dental Plan does not provide coverage for Class I, II, III, or TMJ services performed by a non-PPO Dentist. Orthodontic procedures covered by this Plan may be obtained from non-participating dentists.

Locating a Dentist Via Online Tool (www.DeltaDentalWA.com)

You can find the most current listing of Delta Dental Dentists by going online to the DDWA website at www.DeltaDentalWA.com, click on the Patient tab. Once on the patient tab, type your location and search area into the Find a Dentist tool. If you are enrolled or considering enrolling in the Dental PPO Network Plan, select Delta Dental PPO under the network section. If you are enrolled or considering enrolling in the Dental Open Network Plan, select both Delta Dental PPO and Delta Dental Premier in the network section.

CLAIM FORMS

American Dental Association-approved claim forms may be obtained from your dentist, or you may download claim forms from our website at www.DeltaDentalWA.com or by phoning a Washington (DDWA) customer service representative at **1-206-522-2300** or **1-800-238-3107**.

DDWA is not obligated to pay for treatment performed for which claim forms are submitted for payment more than six months after the date of such treatment. For orthodontia claims, the initial banding date, which is the date the appliance is placed, is the treatment date used to start this six-month period.

CONFIRMATION OF TREATMENT AND COST

You may ask your dentist to complete and submit a request for an estimate, sometimes called a "confirmation of treatment and cost." This will allow you to know in advance what procedures may be covered, the amount DDWA may pay and your expected financial responsibility.

A confirmation of treatment and cost is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination of cost is made and is not a guarantee of payment.

In the event your benefits are terminated, and you are no longer eligible, the confirmation of treatment and cost is voided. DDWA will make payments based on your available benefits (maximum, deductible and other limitations as described in this Summary Plan Description) and the applicable Plan provisions when the treatment is provided.

LIMITATIONS AND EXCLUSIONS

Dental plans typically include limitations and exclusions, meaning that the plans do not cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this Summary Plan Description under the sections called "Benefits Covered by Your Plan", "General Limitations" and "General Exclusions." They warrant careful reading.

REIMBURSEMENT LEVELS

Your dental Plan offers three classes of covered treatment. Each class also specifies limitations and exclusions. For a summary of reimbursement levels for your plan, see the "Dental Benefits Summary" section in the beginning of Dental Plan section.

Refer to the "Benefits Covered by Your Plan" section for specific covered dental benefits under this plan.

REIMBURSEMENT LEVELS FOR OTHER PROCEDURES

The payment level for covered orthodontic procedures is 50 percent.

The payment level for covered and allowable TMJ procedures is 50 percent.

The payment level for covered dental expenses arising as a direct result of an accidental bodily injury is 100 percent, up to the unused Plan maximum.

COINSURANCE

DDWA will pay a predetermined percentage of the cost of your treatment (see "Reimbursement Levels for Allowable Benefits" under the Dental Benefits Summary) and you are responsible for paying the balance. What you pay is called the coinsurance. It is paid even after a deductible is met, if applicable.

PLAN MAXIMUM

For your plan, the maximum amount payable by DDWA for Class I, II and III covered dental benefits (including dental accident benefits) per eligible person is $2,000 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the Plan maximum based on the incurred date.

The lifetime maximum amount payable by DDWA for orthodontic benefits is $2,000 per eligible person.

The lifetime maximum amount payable by DDWA for TMJ benefits is $5,000 per eligible person, with a calendar year maximum of $1,000 per eligible person.

BENEFIT PERIOD

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this plan, the benefit period is the 12-month period starting the first day of the month, January and ending the last day of the month, December.

PLAN DEDUCTIBLE

Your Plan has a $50 deductible per eligible person each benefit period. This means that from the first payment or payments DDWA makes for covered dental benefits, a deduction of $50 is taken. This deduction is owed to the provider by you. Once each eligible person has satisfied the deductible during the benefit period, no further deduction will be taken for that eligible person until the next benefit period. The maximum deductible for all members of a family (Enrolled Employee and one or more Enrolled Dependents) each benefit period is three times the individual deductible. This means that the maximum amount that will be deducted for all members of a family during a benefit period will not exceed $150. Once a family has satisfied the maximum deductible amount during the benefit period, no further deduction will apply to any member of that family until the next benefit period.

The deductible does not apply to:

- Class I covered dental benefits;
- Orthodontic benefits; and
- Accidental Injury benefits.

EXTENSION OF BENEFITS

In the event a person ceases to be eligible for enrollment, or ceases to be enrolled, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise benefits under the terms of this plan.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or individual may be committing insurance fraud, please contact the DDWA hotline for Fraud & Abuse at **1-800-211-0359** or **1-206-985-5927**. You may also want to alert any of the appropriate law enforcement authorities listed:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at **1-800-835-6422** (callers do not have to disclose their names when reporting fraud to the NICB); and
- The Office of the Insurance Commissioner (OIC) at **1-800-562-6900** or go to www.insurance.wa.gov for more information.

MySmile® Personal Benefits Center

The MySmile® personal benefits center, available on DDWA's website at www.DeltaDentalWA.com, is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your Plan network, review your recent dental activity, check details of your Plan coverage, view and print your ID card, check the status of current claims, and more.

For your convenience, your DDWA dental benefits ID card can be found — and printed — directly from the middle of your MySmile personal benefits center portal page.

Health Insurance Portability and Accountability Act (HIPAA)

DDWA is committed to protecting the privacy of your dental health information.

The Health Insurance Portability and Accountability Act (HIPAA) requires DDWA to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.DeltaDentalWA.com. You may also request a printed copy by calling the DDWA privacy hotline at **1-800-554-1907**.

Conversion Option

If your dental coverage stops because your employment or eligibility ends or the group policy ends, you may apply directly to DDWA to obtain coverage under a Delta Dental Individual and Family plan. The benefits and Premium costs may be different from those available under your current plan. To avoid any potential waiting periods, your new coverage must be effective within 63 days of any prior coverage.

You may learn about our Individual and Family plans and apply for coverage online at www.DeltaDentalCoversMe.com or by calling **1-888-899-3734**.

Necessary vs. Not Covered Treatment

You and your provider should discuss which services may not be covered dental benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are covered by your plan. However, there are certain treatments that remain the responsibility of the patient.

Benefits Covered By Your Plan

The following are the covered dental benefits under this Plan and are subject to the limitations and exclusions (refer also to "General Limitations and General Exclusions") contained in this Summary Plan Description. Such benefits (as defined) are available only when provided by a licensed dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

NOTE: *Please be sure to consult your provider before treatment begins regarding any charges that may be your responsibility.*

The amounts payable by DDWA for covered dental benefits are described on your Dental Benefits Summary section.

CLASS I BENEFITS

Class I — Diagnostic

Covered Dental Benefits

- Comprehensive, or detailed and extensive oral evaluation.
- Diagnostic evaluation for routine or emergency purposes (dental exam).
- X-rays.

Limitations

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as a periodic oral evaluation.
- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.
- A complete series or a panoramic X-ray is covered once in a five-year period from the date of service.
- Any number or combination of x-rays, with the exception of a Panoramic X-ray, billed for the same date of service, where the combined fees are equal to or exceed the allowed fee for a Complete Series, will be considered a Complete Series for payment and benefit limitation purposes.
- Supplementary bitewing X-rays are covered once in a benefit period.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits. See "Temporomandibular Joint Benefits" section.

Exclusions

- Consultations.
- Study models.

Class I — Preventive

Covered Dental Benefits

- Prophylaxis (cleaning).
- Periodontal maintenance.
- Topical application of fluoride including fluoridated varnishes.
- Sealants.
- Space maintainers.
- Preventive resin restoration.

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period. Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.

- Topical application of fluoride or preventive therapies (but not both) is limited to two covered procedures in a benefit period through age 18.
- Fissure sealants:
  - Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
  - The application of a fissure sealant is a covered dental benefit once in a two-year period per tooth from the date of service.
- Space maintainers are covered once in a patient's lifetime through age 13 for the same quadrant. Preventive resin restorations:
  - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
  - The application of a preventive resin restoration is a covered dental benefit once in a two-year period per tooth from the date of service.
  - The application of preventive resin restoration is not a paid covered benefit for two years after a fissure sealant or preventive resin restoration on the same tooth from the date of service.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction, and home fluoride kits).

Class I — Periodontics

Covered Dental Benefits

- Prescription-strength fluoride toothpaste.
- Antimicrobial rinse dispensed by the dental office.

Limitations

- Prescription-strength fluoride toothpaste and antimicrobial rinse are covered dental benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's DDWA history must show a periodontal procedure within the previous 180 days.
- Antimicrobial rinse may be dispensed once per course of periodontal treatment. (A course of treatment may include several visits).
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

Class I — Palliative Treatment

Covered Dental Benefits

- Palliative treatment for pain.

Limitations

- Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

CLASS II BENEFITS

Class II — Sedation

Covered Dental Benefits

- General anesthesia when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing, and privileging guidelines established by the state in which the services are provided.
- Intravenous sedation when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing, and privileging guidelines established by the state in which the services are provided.

Limitations

- General anesthesia is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III, TMJ or Orthodontic covered dental benefits.

  Intravenous moderate sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by DDWA*.

  * ***NOTE:*** *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section" for additional information.*
- Either general anesthesia or intravenous sedation (but not both) are covered when performed on the same day.
- General anesthesia or intravenous sedation for routine postoperative procedures is not a paid covered benefit.

Class II — Restorative

Covered Dental Benefits

- Restorations (fillings).
- Stainless steel crowns.
- Posterior composites.
- Refer to "Class III Restorative" if teeth are restored with crowns, inlays, veneers, or onlays.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay);
  - Fracture resulting in significant loss of tooth structure (missing cusp); and
  - Fracture resulting in significant damage to an existing restoration.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
- Stainless steel crowns are covered once in a two-year period from the seat date.

Exclusions

- Overhang removal.
- Copings.
- Re-contouring or polishing of restoration.

Class II — Oral Surgery

Covered Dental Benefits

- Removal of teeth.
- Preparation of the mouth for insertion of dentures.
- Treatment of pathological conditions and traumatic injuries of the mouth.
- Refer to "Class II Sedation" for Sedation information.

Exclusions

- Bone replacement graft for ridge preservation.
- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
- Orthognathic surgery or treatment.
- Tooth transplants.
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

Class II — Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth.
- Services covered include:
  - Periodontal scaling / root planning:
  - Periodontal surgery;
  - Limited adjustments to occlusion (eight teeth or fewer); and
  - Gingivectomy.
- Refer to "Class I Preventive" for periodontal maintenance benefits.
- Refer to "Class II Sedation" for Sedation information.
- Refer to "Class III Periodontics" for occlusal equilibration and occlusal guard.

NOTE: *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment. See "Predetermination of Benefits" for additional information.*

Limitations

- Periodontal scaling/root planing is covered once in a 24-month period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
- Soft tissue grafts (per site) are covered once in a three-year period from the date of service.

Exclusions

- Major (complete) occlusal adjustment.

Class II — Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment;
  - Pulpotomy; and
  - Apicoectomy.
- Refer to "Class II Sedation" for Sedation information.

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a dentist other than the dentist who performed the original treatment and if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

Exclusions

- Bleaching of teeth.

CLASS III BENEFITS

Class III — Restorative

Covered Dental Benefits

- Crowns, veneers, inlays (as a single tooth restoration — with limitations) or onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- Crown buildups.
- Implant supported crowns.
- Post and Core on Endodontically Treated Teeth

Limitations

- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made once in a two-year period, with any difference in cost being the responsibility of the covered person.
- Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- A crown buildup is covered for a non-endodontically treated posterior (back) tooth only when one cusp is missing down to, or closer than, 2mm from the gum tissue in preparation for a restorative crown.
- A crown buildup is covered for an endodontically or a non-endodontically treated anterior (front) tooth only when more than 1/2 of the mesial-distal width of the incisal edge is missing down past the junction of the incisal and middle third of the tooth in preparation for a restorative crown.
- A crown buildup or a post and core are covered once in a seven-year period on the same tooth from the date of service.
- Crown buildups or post and cores are not a paid covered benefit within two years of a restoration on the same tooth from the date of service.

- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- Ceramic substrate/porcelain or cast metal crowns and onlays are not a paid covered benefit for children under 12 years of age.

Exclusions

- Copings.
- A core buildup is not billable with placement of an onlay, 3/4 crown, inlay or veneer.
- A crown or onlay is not a paid Covered Dental Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations.

Class III — Periodontics

These benefits are available for patients with periodontal Pocket depth readings of 5mm or greater only, as determined by your dentist. It is strongly recommended that prior to treatment you have your dentist submit a Confirmation of Treatment and Cost to determine if the planned treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment.

Covered Dental Benefits

- Occlusal-guard (nightguard).
- Repair and relines of occlusal-guard.
- Complete occlusal equilibration.

Limitations

- Occlusal-guard is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Class III — Prosthodontics

Covered Dental Benefits

- Dentures.
- Fixed partial dentures (fixed bridges).
- Inlays when used as a retainer for a fixed partial denture (fixed bridge).
- Removable partial dentures.
- Adjustment or repair of an existing prosthetic appliance.
- Surgical placement or removal of implants or attachments to implants.

Limitations

- Replacement of an existing fixed or removable partial denture is covered once every seven years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Fixed prosthodontics for children less than 16 years of age are not a paid Covered Dental Benefit.

- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer for a fixed bridge), and removable partial dentures shall be paid upon the seat/delivery date.
- Implants and superstructures are covered once every seven years.
- Temporary denture — DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- Stayplate dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth.
- Full and immediate dentures — DDWA will allow the cost of a full or immediate denture toward the cost of an elective procedure such as an overdenture, a personalized restoration, or a specialized treatment.*
- Denture adjustments and relines — denture adjustments and relines done more than six months after the initial placement are covered two times in a 12-month period. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions

- Crowns in conjunction with overdentures.
- Duplicate dentures.
- Personalized dentures.
- Copings.
- Maintenance or cleaning of a prosthetic appliance.
- Root canals in conjunction with overdentures.

* ***NOTE:*** *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.*

Orthodontic Benefits for Adults and Eligible Children

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The lifetime maximum amount payable by DDWA for orthodontic benefits provided to an enrolled person shall be $2,000. Not more than $1,000 of the maximum, or one-half of DDWA's total responsibility shall be payable at the time of initial banding. Subsequent payments of DDWA's responsibility shall be made on a monthly basis throughout the length of treatment submitted.

NOTE: *It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, DDWA prior to commencement of treatment. A predetermination is not a guarantee of payment. See "Predetermination of Benefits" for additional information. Additionally, payment for orthodontic benefits is based upon eligibility. If individuals become disenrolled prior to the payment of benefits, subsequent payment is not covered.*

Covered Dental Benefits

- Treatment of malalignment of teeth and/or jaws. Orthodontic records: exams (initial, periodic, comprehensive, detailed, and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

- Payment is limited to:
  - Completion, or through limiting age (refer to "Dependent Eligibility and Termination"), whichever occur first; and
  - Treatment received after coverage begins (claims must be submitted to DDWA within the time limitation stated in the Claim Forms Section of the start of coverage). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.

- Treatment that began prior to the start of coverage will be prorated:
  - Payment is made based on the balance remaining after charges prior to the date of eligibility are deducted; and
  - DDWA will issue payments based on our responsibility for the length of the treatment. The payments are issued providing the employee is enrolled and the dependent is in compliance with the age limitation.
- In the event of termination of the treatment Plan prior to completion of the case or termination of this plan, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

- Charges for replacement or repair of an appliance.
- Self-Administered Orthodontics.

Temporomandibular Joint Benefits

For the purpose of this plan, Temporomandibular Joint (TMJ) treatment is defined as dental services provided by a licensed dentist for the treatment of disorders associated with the temporomandibular joint. TMJ disorders shall include those disorders that have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

"Dental Services" are those that are:

- Appropriate, as determined by DDWA, for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- Recognized as effective, according to the professional standards of good dental practice; and
- Not experimental or primarily for cosmetic purposes.

Services covered will be both surgical and non-surgical. Non-surgical procedures shall include but are not limited to:

- TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device, removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis, and manipulation under anesthesia.

The maximum amount payable by DDWA for dental services related to the treatment of TMJ disorders shall be $1,000 per covered person, after the application of deductibles, if applicable and coinsurance, in any benefit period, and a lifetime benefit of $5,000 per covered individual. The amounts payable for TMJ benefits during the benefit period shall not be applied to the covered person's annual Plan maximum.

NOTE: *It is strongly suggested that a TMJ treatment plan be submitted to, and a predetermination be made by, DDWA prior to commencement of treatment. A predetermination is not a guarantee of payment. See "Predetermination of Benefits" for additional information.*

In addition to the limitations and exclusions set forth in this Summary Plan Description, the following also apply to TMJ benefits:

- Any procedures, which are defined as TMJ services as stated above, but which, may otherwise be services covered under the provisions of this plan, shall be considered defined under the Plan and subject to all the terms and provisions thereof, and are not covered under this TMJ portion of the plan.

Well Baby Checkups

For your infant child, DDWA offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in your dental Plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure your physician offers this type of services. When visiting a

participating physician with your infant (age 0-3), DDWA will reimburse the physician on your behalf for specific services performed, up to the amount listed below:

- Oral Evaluation: Reimbursed up to $43; and
- Topical application of fluoride: Reimbursed up to $36.

Please see the *"Benefits Covered by Your Plan"* section of this Summary Plan Description for any other limitations. Also, please be aware that DDWA has no control over the charges or billing practices of non-dentist providers which may affect the amount DDWA will pay and your financial responsibility.

Accidental Injury

DDWA will pay 100 percent of the filed fee or the maximum allowable fee for Class I, Class II and Class III covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused Plan maximum. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage is available during the benefit period and includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

GENERAL EXCLUSIONS

This Plan does not cover every part of the dental care you may need. The benefits covered under this plan are subject to limitations listed above which affect the type or frequency of procedures which will be reimbursed. Additionally, there are exclusions to the type of services covered. These limitations and exclusions are detailed with the specific benefits listed above and in this General Exclusion section. These limitations and exclusions warrant careful reading.

These items are not paid Covered Dental Benefits under this Plan.

- Dentistry for cosmetic reasons.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
- Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
- Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
- Experimental services or supplies. This includes:
  - Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
    - The services are in general use in the dental community in the state of Washington;
    - The services are under continued scientific testing and research;
    - The services show a demonstrable benefit for a particular dental condition; and
    - They are proven to be safe and effective.
  - Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
  - Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such an appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.

  - Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review.
- Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
- Prescription drugs.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
- Charges for missed appointments.
- Behavior management.
- Completing claim forms.
- Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), this does not include Occlusal-guard, see "Class III Periodontics" for benefit information.
- This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

DDWA shall determine whether services are Covered Dental Benefits in accordance with a standard dental practice and the Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this benefit booklet and may seek judicial review of any denial of coverage of benefits.

All other services not specifically included in this Plan as covered dental benefits.

NOTE: *DDWA shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown in this Summary Plan Description. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this Summary Plan Description and may seek judicial review of any denial of coverage of benefits.*

FREQUENTLY ASKED QUESTIONS ABOUT YOUR DENTAL BENEFITS

What is a Delta Dental "participating dentist"?

A Delta Dental participating dentist is a dentist who has signed an agreement with Delta Dental stipulating that he or she will provide dental treatment to subscribers and their dependents covered by DDWA's group dental care plans. Delta Dental participating dentists submit claims directly to DDWA for their patients.

NOTE: *The PPO Network Dental Plan provides coverage for services received from a Delta Dental PPO Dentist only.*

Can I choose my own dentist?

See *"Finding a Dentist"* in the *"How to Use Your Plan"* section in the front of this benefit Summary Plan Description, under "Choosing a Dentist."

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your dentist. You can also obtain a copy of the approved claim form from our website at www.DeltaDentalWA.com.

NOTE: *If your dentist is a Delta Dental participating provider, he or she will complete and submit claim forms for you.*

What is the mailing address for DDWA claim forms?

If you see a Delta Dental participating dentist, the dental office will submit your claims for you. If your dentist is not a participating dentist, it will be up to you to ensure that the dental office submits your claims to Delta Dental of Washington at P.O. Box 75983, Seattle, WA 98175-0983.

Who do I call if I have questions about my dental Plan benefits?

If you have questions about your dental benefits, call DDWA's customer service department at **1-206-522-2300** or call toll-free at **1-800-554-1907**. Questions can also be addressed via e-mail at cservice@DeltaDentalWa.com.

Do I have to get an "estimate" before having dental treatment done?

You may ask your dentist to complete and submit a request for an estimate, called a "Confirmation of Treatment and Cost." The estimates provided do not represent a guarantee of payment, but they provide you with estimated costs and benefits for your procedure.

What is Delta Dental?

Delta Dental Plans Association is a national organization made up of local, nonprofit Delta Dental plans that provide employer groups with dental benefits coverage. DDWA is a member of the Delta Dental Plans Association.

GLOSSARY

Alveolar

Pertaining to the ridge, crest, or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam

A mostly silver filling often used to restore decayed teeth.

Apicoectomy

Surgery on the root of a tooth.

Appeal

A written or verbal request of consideration submitted by or on behalf of a subscriber or patient regarding the denial, modification, reduction or terminate of payment, coverage, authorization, or provision of health care services or benefits.

Bitewing X-ray

An X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gum line, as well as a portion of the roots and supporting structures of these teeth.

Bridge

A replacement for a missing tooth or teeth. The bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

Certificate of Coverage

The Summary Plan Description which describes in summary form the essential features of the contract coverage, and to or for whom the benefits hereunder are payable.

Caries

Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Complaint

An oral or written report by a subscriber or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

Comprehensive Oral Evaluation

Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

Contract

The agreement between DDWA and T-Mobile. The Contract constitutes the entire Contract between the parties and supersedes any prior agreement, understanding or negotiation between the parties.

Coping

A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. The purpose of a coping is to allow the removal and modification of the bridge without requiring a major remake of the bridgework if the tooth is lost.

Covered Dental Benefits

Those dental services that are covered under this Contract, subject to the limitations set forth in Benefits Covered by Your Plan.

Crown

A restoration that replaces the entire surface of the visible portion of tooth.

DDWA

Delta Dental of Washington, a non-profit corporation incorporated in Washington State. DDWA is a member of the Delta Dental Plans Association.

Delivery Date

The date a prosthetic appliance is permanently cemented into place.

Delta Dental

Delta Dental Plans Association, which is a nationwide non-profit organization of health care service plans, which offers a range of group dental benefit plans.

Delta Dental PPO Dentist

A Participating Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental PPO Participating Dentist Agreement between the Participating Plan and such Dentist, which includes looking solely to Delta Dental for payment for covered services.

Delta Dental Participating Dentist

A licensed Dentist who has agreed to render services and receive payment in accordance with the terms and conditions of a written Delta Dental Participating Dentist Agreement between Delta Dental and such Dentist, which includes looking solely to Delta Dental for payment for covered services.

Dentist

A licensed dentist legally authorized to practice dentistry at the time and in the place, services are performed. This Contract provides for covered services only if those services are performed by or under direction of a licensed Dentist or other DDWA-approved Licensed Professional. A Dentist does not mean a dental mechanic or any other type of dental technician.

Denture

A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

Eligibility Date

The date on which an Eligible Person becomes eligible to enroll in the Plan.

Eligible Dependent

Any dependent of an Eligible Employee who meets the conditions of eligibility

Eligible Employee

Any employee who meets the conditions of eligibility.

Eligible Person

An Eligible Employee or an Eligible Dependent.

Emergency Dental Condition

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

Emergency Examination

Also known as a "limited oral evaluation — problem focused." Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

Endodontics

The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Enrolled Dependent, Enrolled Employee, Enrolled Person

Any Eligible Dependent or Eligible Employee as applicable, who has completed the enrollment process and for whom Group has submitted the monthly Premium to DDWA.

Exclusions

Those dental services that are not contract benefits set forth in Benefits Covered by Your Plan and all other services not specifically included as a Covered Dental Benefit set forth in Benefits Covered by Your Plan.

Filed Fees

Approved fees that participating Delta Dental participating dentists have agreed to accept as the total fees for the specific services performed.

Filled Resin

Tooth-colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

Fluoride

A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish

A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

General Anesthesia

A drug or gas that produces unconsciousness and insensibility to pain.

Group

The employer or entity that is contracting for the dental benefits described in this Summary Plan Description for its employees.

Implant

A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay

A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intraoral X-rays Complete Series (including bitewings)

A series of radiographs which display the root and coronal portions of all the teeth in the mouth.

Intravenous (I.V.) Sedation

A form of sedation whereby the patient experiences a lowered level of consciousness but is still awake and can respond.

Licensed Professional

An individual legally authorized to perform services as defined in their license. Licensed professional includes, but is not limited to, denturist, hygienist, and radiology technician.

Limitations

Those dental services that are subject to restricting conditions set forth in Benefits Covered by Your Plan.

Localized Delivery of Antimicrobial Agents

Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees

The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Night Guard

See “Occlusal Guard”.

Nonparticipating Dentist

A licensed Dentist who has not agreed to render services and receive payment in accordance with the terms and conditions of a written Participating Dentist Agreement between a member of the Delta Dental Plans Association and such Dentist.

Not a Paid Covered Benefit

Any dental procedure that, under some circumstances, would be covered by DDWA, but is not covered under other conditions. Examples are listed in Benefits Covered by Your Plan.

Occlusal Adjustment

Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal Guard

A removable dental appliance — sometimes called a night guard — that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard (night guard) is typically used at night.

Onlay

A restoration of the contact surface of the tooth that covers the entire surface.

Open Enrollment Period

The annual period in which subscribers can select benefits plans and add or delete eligible dependents.

Orthodontics

Diagnosis, prevention, and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture

A removable denture constructed over existing natural teeth or implanted studs.

Palliative Treatment

Services provided for emergency relief of dental pain.

Panoramic X-ray

An X-ray, taken from outside the mouth that shows the upper and lower teeth and the associated structures in a single picture.

Participating Plan

Delta Dental of Washington, and any other member of the Delta Dental Plans Association, with which Delta Dental contracts to assist in administering the Benefits described in this Summary Plan Description.

Payment Level

The applicable percentage of Maximum Allowable Fees for Covered Dental Benefits that shall be paid by DDWA as set forth in the Summary of Benefits and Reimbursement Levels sections of this Summary Plan Description.

Periodic Oral Evaluation (Routine Examination)

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics

The diagnosis, prevention, and treatment of diseases of gums and the bone that supports teeth.

Plan

The dental benefits as provided and described in this Summary Plan Description. Any other booklet or contract that provides dental benefits and meets the definition of a "Plan" in the "Coordination of Benefits" section of the Certificate of Coverage is a Plan for the purpose of coordination of benefits.

Premium

The monthly amount payable to DDWA by T-Mobile, and/or by Enrolled Employee to T-Mobile, as designated in the Contract.

Prophylaxis

Cleaning and polishing of teeth.

Prosthodontics

The replacement of missing teeth by artificial means such as bridges and dentures.

Pulpotomy

The removal of nerve tissue from the crown portion of a tooth.

Qualified Medical Child Support Order (QMCSO)

An order issued by a court under which an employee must provide medical coverage for a dependent child. QMCSO's are often issued, for example, following a divorce or legal separation.

Resin-Based Composite

A tooth-colored filling, made of a combination of materials, used to restore teeth.

Restorative

Replacing portions of lost or diseased tooth structure with a filling or crown to restore proper dental function.

Root Planing

A procedure done to smooth roughened root surfaces.

Sealants

A material applied to teeth to seal surface irregularities and prevent tooth decay.

Seat Date

The date a crown, veneer, inlay or onlay is permanently cemented into place on the tooth.

Specialist

A licensed Dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or holds a diploma from an American Dental Association recognized certifying board.

Temporomandibular Joint

The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Veneer

A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention.

CLAIM REVIEW AND APPEAL

Confirmation of Treatment and Cost

A Confirmation of Treatment and Cost is a request made by your dentist to DDWA to determine your benefits for a particular service. This Confirmation of Treatment and Cost will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A Confirmation of Treatment and Cost is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination is made. It is not a guarantee of payment (please refer to the "Initial Benefits Determination" section regarding claims requirements).

A standard Confirmation of Treatment and Cost is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete DDWA will notify you and your Dentist in writing that additional information is required in order to process the Confirmation of Treatment and Cost. Once the additional information is available your Dentist should submit a new request for a Confirmation of Treatment and Cost to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the Confirmation of Treatment and Cost is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

Urgent Confirmation of Treatment and Cost Requests

Should a Confirmation of Treatment and Cost request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, DDWA will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, DDWA may provide notice of determination orally with written or electronic confirmation to follow within 72 hours. Immediate treatment is allowed without a requirement to obtain a Confirmation of Treatment and Cost in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to DDWA for payment, modification, or denial of services. In accordance with regulatory requirements, DDWA processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification;
- Reference to the specific Plan provision on which the determination was based; and

- Your appeal rights should you wish to dispute the original determination.

APPEALS OF DENIED CLAIMS

How to Contact Us

We will accept notice of an Urgent Care Grievance or Appeal if made by you, your covered dependent, or an authorized representative of your covered dependent orally by contacting us at the telephone number below or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents, or other information that you believe supports your claim. For more information, please call 1-800-554-1907.

Authorized Representative

You may authorize another person to represent you or your child and receive communications from DDWA regarding your specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form, or appropriate written authorization in another format is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

Informal Review

If your claim for dental benefits has been completely or partially denied, you have the right to request an informal review of the decision. Either you, or your authorized representative (see above), must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and include the following information:

- Your name and ID number;
- The claim number (from your Explanation of Benefits form); and
- The name of the dentist.

DDWA will review your claim and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may make a written request that your claim be reviewed formally by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information submitted with your informal review request plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim within 30 days of receiving your request. Upon completion of their review the Appeals Committee will send you written notification of their decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could

jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulation.

Subrogation

Based on the following legal criteria, subrogation means that if you receive this Plan's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss, any money recovered in excess of full compensation must be used to reimburse DDWA. DDWA will prorate any attorneys' fees against the amount owed.

To the extent of any amounts paid by DDWA for a covered person on account of services made necessary by an injury to or condition of their person, DDWA shall be subrogated to their rights against any third party liable for the injury or condition. DDWA shall, however, not be obligated to pay for such services unless and until the covered person, or someone legally qualified and authorized to act for him or her, agrees to:

- Include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;
- Repay DDWA those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received; and
- Cooperate fully with DDWA in asserting its rights under the contract, to supply DDWA with any and all information and execute any and all instruments DDWA reasonably needs for that purpose.

Provided the injured party is in compliance with the above, DDWA will prorate any attorneys' fees incurred in the recovery.

SUBSCRIBER RIGHTS AND RESPONSIBILITIES

At DDWA our mission is to provide quality dental benefit products to employers and employees through the largest network of participating dentists. We view our benefit packages as a partnership between DDWA, our subscribers and our participating member dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have the Right to:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental member/nonmember), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact DDWA customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at www.DeltaDentalWA.com.
- Appeal orally or in writing, decisions, or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional, and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational, or religious background.

To Receive the Best Oral Health Care Possible, it is Your Responsibility to:

- Know your benefit coverage and how it works.

- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours' notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents that you are requested to sign and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to DDWA to assist with the processing of claims, predeterminations or appeals.
- If applicable, pay the dental office the appropriate copayments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

Vision Plan (administered by Vision Service Plan)

VISION BENEFITS SUMMARY

Vision Service Plan (VSP) Group #12122822		Maximums and Limits (Plan Year is January 1 through December 31)	All Plans	
			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 per pair after $25 copay
	Lined Bifocal		100% after $25 copay	Reimbursed up to $50 per pair after $25 copay
	Lined Trifocal		100% after $25 copay	Reimbursed up to $65 per pair after $25 copay
	Elective Contact Lenses		100%, up to $200 for contacts; Separate copay (up to $60) for contact lens exam — fitting and evaluation.	Reimbursed up to $105 per pair (no copay)
	Medically Necessary Contacts		100% after $25 copay	Reimbursed up to $210 per 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
LightCare		Once every plan year Enrolled employees and covered dependents can use the frame and lens benefit to get non-prescription sunglasses or blue-light filtering glasses. Coverage in lieu of prescription eyewear	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. Not available at all retail chain providers.	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 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.

Finding a VSP Doctor

Vision Service Plan (VSP) offers different ways to help you find a VSP doctor in your area, or to verify that your current provider is a VSP doctor.

You may use different VSP doctors for your examination and your glasses or contact lenses. However, you will want to make sure to check with the dispensing doctor's office to assure that he or she will fill another doctor's prescription.

Online Provider Directory

Utilizing the Internet is the easiest way to select a doctor. You simply go online to the VSP web site at t-mobile.vspforme.com.

Create an account or log in (if you already have an account) before searching to ensure you see an in-network eye doctor for your plan. Click on Members and select the *Find a Doctor* option. You can search by *Location*, *Office* and *Doctor*.

Automated Member Service System

Vision Service Plan offers an automated member service system accessible via a toll-free number. By calling **1-800-877-7195**, you can:

- Request a list of VSP doctors be mailed directly to you, or
- Enter a doctor's telephone number to verify the office's participation in VSP's network.

Should you need additional assistance, a customer service representative is available.

Out-of-Network Provider

If you wish to see an out-of-network provider, the Plan will reimburse you up to the amount allowed under the out-of-network provider reimbursement schedule. (See chart in the **Vision Benefit Summary** section of this handbook.) Be aware that your out-of-network provider reimbursement schedule does not guarantee full payment. Also, please note that services obtained from out-of-network providers are subject to the same copayments and limitations as services obtained from VSP member doctors.

How to Use Your Benefits

Call your doctor and make an appointment. When you call your doctor to make an appointment, always make sure to identify yourself as a VSP member, and give them the following information:

- Your name and date of birth;
- The company name, T-Mobile USA, Inc.; and
- The last 4 digits of the T-Mobile employee's Social Security number.

After you make an appointment, your doctor and VSP will handle the rest. The doctor will check your eligibility for services and plan coverage.

During your doctor visit, ask whether the services and materials that you want are covered by your VSP plan. Please keep in mind that you may choose lenses or lens enhancements that are not necessary for your visual welfare but that are desired for cosmetic reasons and may not be covered by the Plan. Examples are tints, custom and premium progressive lenses, and scratch-resistant coatings.

Pay your doctor for any copayments and other costs not covered by your Plan. Your Plan pays the doctor for services and materials covered by your Plan. If you have problems with your eligibility, contact VSP Member Services at **1-800-877-7195**.

If you receive unsatisfactory services or materials from a VSP doctor, contact VSP Member Services at **1-800-877-7195**.

Additional Information on Your Vision Benefits

You are allowed one examination, one pair of lenses and a frame per plan year (which begins on January 1). Or you can choose to obtain Contact lenses (elective or medically necessary) in lieu of lenses and frames within the same plan year.

Lenses and Frames

When materials are received from a VSP doctor, you will have no out-of-pocket expense other than the copayment, unless optional items are selected. Optional items include, but are not limited to, oversize lenses (61mm or larger), tinted lenses, custom and premium progressive multifocal lenses, treatments for cosmetic reasons or a frame that exceeds the plan allowance.

One $25 copay applies to both lenses and frames per Plan year. Copay is only applied once to either lenses or frames, but not both during the plan year.

Your plan will provide 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

Although there are a wide variety of frames covered under your Plan, you should always ask your VSP doctor which frames are covered in full when deciding on a frame. If you choose a frame valued at more than the plan's allowance, you will receive a 20 percent discount on the amount over the allowance.

Contact Lenses

Elective contact lenses are covered instead of a complete pair of prescription glasses. An allowance of $200 in-network applies toward contact lenses. The contact lens fitting and evaluation (contact lens exam) is covered in full after a not to exceed $60 copay. An allowance of $105 out-of-network applies toward contact lens fitting and evaluation exam and materials. In order to receive contact lenses, you must be eligible for lenses. Frame eligibility is not required. When you choose contact lenses, you use your eligibility for both lenses and frames. In other words, if you elect contact lenses, you will again be eligible for lenses and a frame the following plan year.

If the contacts selected exceed your maximum allowance, you are responsible for the payment of any remaining balance. Your Plan includes a 15% discount off of the VSP doctor's professional services (evaluation and fitting) when buying contact lenses. Materials are provided at the doctor's customary fees.

Medically necessary contact lenses must be prescribed by a VSP member doctor for certain conditions. Your VSP doctor will determine eligibility for these types of lenses at the time of service.

Low Vision Benefit

The Low Vision benefit is available for severe visual problems that are not correctable with regular lenses and is subject to prior approval by VSP Consultants.

Supplementary Testing:	Coverage includes two low vision supplemental exams every two years. VSP pays up to $125 for each exam.
	Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
Supplemental Care Aids:	75% of Cost.
	Subsequent low vision aids as Visually Necessary or Appropriate.
Copayment for Supplemental Aids:	25% payable by Covered Person plus any amount over the benefit maximum.
Benefit Maximum:	The maximum benefit available is $1,000 (excluding Copayment) every two years.

Non-Member Provider Benefit

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above. You should pay the Non-Member Provider their full fee. Once VSP receives the claim, it will be reviewed for approval. If approved, reimbursement will be in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances.

NOTE: *There is no assurance that this amount will be within the 25% Copayment feature.*

Emergency Vision Care

Services for medical conditions, including emergencies, are not covered by VSP, but through the Medical Plan. For emergency conditions of a non-medical nature, such as lost, broken, or stolen glasses, you should contact VSP's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Plan.

VISION GENERAL EXCLUSIONS AND LIMITATIONS

Vision benefits are not paid for exams, frames or lenses purchased more frequently than specified in the above **Vision Benefit Summary**. In addition, no benefits will be paid for:

- Non-prescription lenses with the exception of the LightCare benefit;
- Orthoptics or visual training and any associated supplemental testing;
- Examinations in connection with medical or surgical treatment;
- Replacement of lost or broken lenses and frames except at the normal intervals when services are otherwise available;
- Second pair of glasses in lieu of bifocals;
- Examinations required by governmental body, such as to obtain a driver's license;
- Cosmetic materials, for example oversized lenses or tinted lenses;
- Services for which no charge is made, or no payment would be required if you did not have this coverage;
- Amounts charged for failure to keep a scheduled appointment (no show charges);
- Services provided under a plan or program operated by a national, state, or local government, or one of their agencies, unless the services were provided on an emergency basis;
- Services furnished or payable under any other group insurance plan;
- Injury or illness resulting from an act of war;
- Illness covered by Workers' Compensation, occupational disease law or similar laws;
- Injury if it arises out of employment for pay, profit or gain;
- Injury or illness caused by another person or organization;
- Expenses incurred after coverage ends or before coverage begins; or
- Corrective vision services treatments and materials that are considered experimental, investigational, or unproven; that is those not generally accepted by the vision care profession because they are the subject of ongoing clinical trials, they have not been demonstrated as safe and effective for treating or diagnosing the condition for which their use is proposed, or they are drugs or drug therapies which have not been approved for the proposed use by the U.S. Food and Drug Administration or other governing agency.

CLAIMS INFORMATION

Filing Claims

A claim form does not need to be filed when a VSP doctor is used.

If you choose to use an out-of-network provider, the Plan will reimburse you up to the amount allowed under the out-of-network provider reimbursement schedule. (See chart in the **Vision Benefit Summary** section of this handbook).

The following steps should be completed when submitting out-of-network provider bills for reimbursement:

Pay the entire bill when you see the out-of-network provider and gather the following information:

- The provider's bill, including a detailed list of the services you received;
- Your phone number, address, and last 4 digits of the T-Mobile employee's Social Security number;
- The name, date of birth, phone number, and address of the family member who received the benefit, and
- The relationship of that family member to you (self, Spouse, Child).

Although claim forms are not required, forms are available on VSP's website (t-mobile.vspforme.com) and can help timely reimbursement.

Claims must be filed with VSP within six (6) months after seeing the provider. Please keep a copy of the information for your records and send the originals to:

VSP
PO Box 495933
Cincinnati, OH 45249

Claims can also be submitted online on our member portal on t-mobile.vspforme.com. Member will need to register on the website, login and click Benefits and click on the link Submit a Claim.

Complaints and Grievances

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

Initial Determination

VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Request for Appeals

If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

1-800-877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

Other Remedies

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Section 125 Flexible Spending Account (FSA) Plans

PLAN SUMMARY

Section 125 Flexible Spending Account (FSA) Plan	
Health Care Spending Account	
Contributions	■ Maximum of $3,400 as pretax contribution per plan year. ■ If you have unused Health Care Spending Account dollars at the end of the plan year, up to $680 will carry over to the next year. Amounts above $680 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	■ Any unreimbursed health care expenses, such as: ■ Medical, Dental, and Vision copays, coinsurance, and deductibles; ■ Over-the-counter drugs; ■ Any other medical, dental, or vision expenses not covered by our plan that would otherwise be considered deductible for tax purposes by the IRS; and ■ For an expanded list of eligible expenses, go to www.t-mobilebenefits.com.
Limitations	■ Expenses not eligible for reimbursement include: ■ Over-the-counter vitamins or dietary supplements not prescribed by your doctor; ■ Personal care products other than menstrual care products; ■ Insurance premiums and; ■ Cosmetic Surgery.
Dependent Care Spending Account	
Contributions	■ 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.

Childcare Subsidy Program	■ Eligible employees can receive up to $250 per month to help with childcare costs — this amount cannot be used for Elder care. ■ In order to be eligible, an employee must have a gross annual income of $99,000 or less and be benefits eligible. ■ Enrollment in the subsidy program can only occur at initial eligibility, open enrollment or due to a qualifying mid-year status change. ■ The childcare subsidy is a per household/family benefit. ■ For more details, visit t-mobilebenefits.com or call the T-Mobile Benefits Center at **1-855-TMO-BENS (855-866-2367)**.
Reimbursement	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: ■ Dependent child under age 13 for whom you can claim an exemption on your tax return; or ■ Dependent or spouse who is physically or mentally incapable of caring for himself or herself. 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.
Limitations	Expenses not eligible for reimbursement include: ■ 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); and ■ Nursing home expenses. Employees are not eligible to participate in Dependent Care FSA while on LOA per IRS guidelines. Employer subsidy will not be provided while an employee is on LOA but will be funded on the first day of the month following return from LOA.

INTRODUCTION TO THE SECTION 125 PLAN

This chapter of the handbook describes the Internal Revenue Code (IRC) Section 125 Flexible Spending Account Plan that T-Mobile has implemented in order to allow you to choose to use part of your salary to pay the cost of certain Employer-sponsored benefits with pre-tax dollars. **One of the most important features of our Section 125 Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes.** Under a Section 125 Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

DISADVANTAGES OF PARTICIPATION IN THE FLEX PLAN

There may be a few disadvantages for some Employees in electing to participate in all or certain portions of the Flex Plan. These include:

- To the extent you make pre-tax contributions to the Plan, these contributions are not counted as wages for Social Security purposes. This could result in a small reduction in your Social Security retirement benefit when you retire;
- Your election to make pre-tax contributions cannot be changed until the next Plan Year, except due to certain status changes. The Internal Revenue Service requires this strict rule;
- There are minimums and maximums that you can contribute to each account. You must use the money placed in your expense accounts for expenses incurred within the plan year (see "Timeframe to Incur and Submit Claims of Reimbursable Expenses" under the Health Care Spending Account for the exception to this rule) or, under tax law, any remaining balance will be forfeited; and
- Domestic Partners and their children are not eligible for pre-tax savings. Health care expenses for them are not eligible for reimbursement under the Health Care Spending Account.

Before enrolling, you can visit My Choice Account online at www.t-mobilebenefits.com for a list of eligible health care and dependent care expenses and more information about how the program works.

REINSTATEMENT OF FORMER PARTICIPANT

Subject to the Special Rules noted above, if you terminate employment or cease to be an Eligible Employee and are rehired or return to status as an Eligible Employee during the same Plan Year in which you terminated or ceased to be eligible, and the rehire or return to status occurs within 30 days of the termination or cessation, you are required to participate for the remainder of the Plan Year by continuing your original election for that Plan Year on a pro rata basis. If you are rehired within 30 days in a different Plan Year, a new enrollment opportunity is provided. The effective date of coverage is the first of the month following date of rehire.

If more than 30 days pass (but less than 13 weeks pass) and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following date of rehire.

If more than 13 weeks pass and you are rehired or return to status, you may make a new election. The effective date of coverage is the first of the month following 30 days of continuous employment after date of hire.

NONDISCRIMINATION REQUIREMENTS

It is our intent that this Plan operates in a manner that meets the applicable nondiscrimination requirements of the Code. If the Plan Administrator deems it necessary to avoid discrimination under this Plan, it will reject any elections or reduce contributions or Benefits in order to assure compliance with this Section.

CLAIM FOR BENEFITS

Any claim for benefits under any of your Employer's health benefits plans, shall be submitted under the claims procedure or policy under that plan in accordance with the plan document or summary plan description of your health benefits plan. Any claim for Benefits under your Employer's Health Care Spending Account or Dependent Care Spending Account shall be made to MyChoice Account (see Reimbursement Procedures under sections titled Health Care Spending Account and Dependent Care Spending Account). In the event that your claim is denied, in whole or in part, MyChoice Account will notify you within 30 days of receipt of such claim. Should MyChoice Account face delays not of its own creation, MyChoice Account may extend the determination period an additional 15 days only if it notifies you of the delay prior to the exhaustion of the initial 30-day period and in so doing, advises the Participant of the date by which the determination will be made. Should the delay occur as a result of deficient information submitted by you, the extension notice must describe the required information necessary for determination. You shall have 45 days to submit the requested information to MyChoice Account. The notice of a denial of a claim shall be written in a manner calculated to be understood by you and shall set forth:

- The specific reason for the denial;
- Specific references to the pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary;
- A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request); and
- An explanation of the Plan's claims procedure.

Within 180 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Plan Administrator for a full and fair review. The claimant or their duly authorized representative may:

- Request a review upon written notice to MyChoice Account;
- Review pertinent documents; and
- Submit issues and comments in writing to include a copy of the claim form, all documentation used to substantiate the claim, the denial letter and any further documentation to support the appeal.

This request should be sent to:

MyChoice Account
MSC 345475

P.O. Box 105168
Atlanta, GA 30348-5168

claims@mychoiceaccounts.com

Fax: 1-855-883-8542

Appeals are reviewed by MyChoice Account Claims Appeal Board on a weekly basis. Additional information may be requested from the Employee during this process.

A decision on the review by the Plan Administrator will be made no later than 60 days after receipt of a request for review. The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based and a statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in making the adverse determination. The decision shall provide that the Participant may, upon request, receive free copies of any documents, records, or other information relevant to the claim for benefits from MyChoice Account. Should you receive an adverse determination of the appeal, you have the right to file a second appeal. The second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The timing of response to the second appeal shall be made in accordance with the same time guidelines as those outlined for the first appeal.

In carrying out its responsibilities under the Plan, the Plan Administrator has full and final discretion to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. However, the Plan Administrator and Plan Administrator's designated individuals may only receive your Protected Health Information (PHI) (as defined under HIPAA), for the action of determining benefits under the plan, the tracking of your account balance where applicable, and for any uses as required by law. Furthermore, the Plan Administrator may not disclose or use any PHI for employment-related actions or in connection with any other employee benefit plan. The Plan Administrator will make your PHI available to you when you make a request for such information in writing. Any non-compliance by authorized personnel shall be directed to the identified HIPAA privacy officer for review. Finally, the Plan certifies that the plan documents have been amended and the Plan has agreed to certain conditions regarding the use and disclosure of protected health information. For more specific information, please see the Notice of Privacy Practices, as received from the Plan.

HEALTH CARE SPENDING ACCOUNT

You may elect to contribute up to $3,400 per year on a pre-tax basis to a Health Care Spending Account. You will then be entitled to receive reimbursement for eligible Health Care Expenses which are incurred while you are a participant in the Plan by you, your Spouse and dependents, up to the total dollar amount you elected for the Plan Year, less any prior reimbursements

made for that Plan Year. ***NOTE:*** *Expenses of domestic partners and their children are not eligible for reimbursement.* An expense is incurred during the Plan Year if the services giving rise to the expense are performed during the Plan Year, regardless of when you are billed or pay for the service. The expense must be incurred, and the services performed before you may submit the expense for reimbursement. ***NOTE:*** *"Incurred" means an expense is incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for or pays for the medical care.*

Expenses reimbursed from your Health Care Spending Account cannot be deducted on your income tax return, and you cannot be reimbursed for expenses for which you have been reimbursed or which are reimbursable under any other health plan.

If you enroll in the HRA Plan, you can participate in the Health Care Spending Account. However, the HRA will pay first for medical expenses and the Health Care Spending Account will pay for dental and vision expenses and any remaining medical expenses, once the HRA has been used up. UHC HRA participants have the option to shut off the auto rollover and choose whether to use HRA or Health Care Spending Account dollars first, by logging onto www.myuhc.com.

If you enroll in the HSA Plan, you can't participate in a Health Care Spending Account, but you are eligible to participate in a Limited Purpose Health Care Spending Account. You may access your account information online by logging into www.t-mobilebenefits.com or calling the Benefits Center at **1-855-TMO-BENS**. Telephone support is available Monday through Friday, 5 AM to 5 PM Pacific time, excluding holidays.

Eligible Health Care Expenses

Eligible Health Care Expenses include deductibles, copayments, dental and orthodontia expenses, prescription drugs, over-the-counter medications, eye care, hearing care, routine physical examinations, and any other health care item which constitutes "medical care" under Section 213(d) of the Internal Revenue Code. Insurance premiums, however, are **not** eligible medical expenses under your Health Care Spending Account. The Plan Administrator will provide you with additional guidance regarding eligible Health Care Expenses.

Reimbursement Procedures

Prior to the start of the plan year, you will automatically receive a MyChoice Account Debit Card. If you choose to activate it, you can use the card to pay for eligible health care products and services directly from your MyChoiceAccount. You may be required to submit a detailed receipt to show that the card was used to pay for eligible health care expenses. If you are not able to show that the card was used for eligible expenses, you will be required to pay the plan in the amount of the card transaction. If you fail to repay the plan, or substantiate the transaction, your benefit card will be suspended, until such time when the transaction has been repaid. You will still be able to submit manual claims. Card privileges may be revoked at any time due to misuse or abuse.

If you choose not to activate your MyChoice Account Debit Card, your claims for reimbursement must be submitted through your online account at www.t-mobilebenefits.com or by utilizing the MyChoice Mobile App. For support with filing claims, contact the Benefits Center at **1-855-866-2367**.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

Timeframe to Incur and Submit Claims of Reimbursable Expenses

You will have 120 days from the end of the plan year to submit expenses for the current plan year. As a result, the deadline to request reimbursement for qualified expenses for the plan year ending December 31st will be April 30th of each year. If you have unused Health Care Spending Account dollars at the end of the Plan Year, up to $680 will carry over to the next Plan Year. Amounts above $680 will be forfeited. The carryover will remain until the participant is no longer eligible for the Health Care Spending Account through T-Mobile, even if they do not re-enroll in the plan for the following year. This carry over is in addition to the participants' new plan year election.

Account Balance Exceeds Reimbursable Expenses

If there is money in your account at the end of the Plan Year and you have no more reimbursable expenses, IRS rules require that the money in your account be forfeited if the amount exceeds the $680 allowable carry over. In general, forfeited amounts

will be used to pay Plan administrative costs. For this reason, you need to make conservative estimates of your reimbursable expenses for the coming Plan Year when you make your Health Care Spending Account election.

LIMITED USE HEALTH CARE SPENDING ACCOUNT (LUFSA)

Rules and Features

Employees who have carryover funds remaining for the prior plan year and enroll in the HDHP and establish an HSA will have their carryover funds limited to eligible dental and vision expenses.

NOTE: *Employees who enroll in the High Deductible Health Plan are not eligible to enroll in a Health Care Spending Account.*

Because the Carryover Limited-Use Plan is intended to be used in conjunction with a HDHP/ Health Savings Account (HSA), eligible expenses are limited to dental, and vision expenses that are not already covered. Medical care expenses should be paid from your Health Savings Account (HSA).

Examples of Eligible Health Care Expenses

Your share of expenses that are not paid by your dental and/or vision plan, such as deductibles, coinsurance, and copayments and charges that exceed maximum allowed amounts or other plan limits.

Vision care expenses, such as exams, prescription eyeglasses and sunglasses, prescription contact lenses, and laser surgery, which are not covered by your medical or vision plan.

Paying for Your Expenses Out-of-pocket

You can submit claims for certain expenses under the following plans:

- Dental; and
- Vision.

You can pay for your eligible expenses using your MyChoice Account debit card or out-of-pocket and submit qualified expenses for reimbursement using the HCSA Claim Form. You can submit a claim online on the Benefits website at www.t-mobilebenefits.com or the MyChoice Mobile App. Additional claim-filing instructions are available on the Benefits website.

Reimbursements

In order for a claim to be deemed an eligible expense to be reimbursed, you must provide any pertinent documentation to establish that a claim is eligible for reimbursement, which may include providing documentation that a service provided in connection with a claim, was medically necessary.

DEPENDENT CARE SPENDING ACCOUNT

You may elect to contribute up to the lesser of your "earned income" or $7,500 ($3,750 if you are married and filing separately) on a pre-tax basis to a Dependent Care Spending Account. (Your "earned income" is the lesser of your earnings or your Spouse's earnings.) You will then be entitled to receive reimbursement for employment-related Dependent Care Expenses which enable you and your Spouse, if applicable, to work (or to actively seek work) and which are incurred after your election date, but during the Plan Year, up to the current balance in your Dependent Care Spending Account.

NOTE: *"Incurred" means an expense is incurred when the participant is provided with the dependent care services and not when the participant is formally billed or charged for the dependent care services.*

You may access your account information online by logging into www.t-mobilebenefits.com or calling the Benefits Center at **1-855-TMO-BENS**. Telephone support is available Monday through Friday, 5 AM to 5 PM Pacific time, excluding holidays.

Eligible Participants

You must be a single parent, or if you are married, your Spouse must work unless he or she is a full-time student for at least five months during the year while you are working or is physically or mentally unable to care for himself or herself. If you are divorced or legally separated, you must have custody of your Child most of the time even though your former Spouse may claim the Child for income tax purposes. If your Spouse is a full-time student or is physically or mentally incapable of caring for himself or herself, he or she will be deemed to be earning $250 per month (if you receive care for one dependent) or $500 per month (for two or more dependents).

Dependents Eligible for Care

You may receive reimbursement for employment-related Dependent Care Expenses for the care of "qualifying dependents." Qualifying dependents are Children under age 13 whom you claim as dependents for income tax purposes, or your Spouse or other dependent who is physically or mentally unable to care for himself or herself (even if you cannot claim an exemption for the person for income tax purposes). You may also claim care expenses for the care of an elderly parent who spends at least eight hours a day in your home and whom you can claim as a dependent.

Employment-Related Dependent Care Expenses

You may be reimbursed for care provided inside or outside your home by anyone other than your Spouse, your Child under age 19, and/or any person you claim as a dependent for income tax purposes. If the care is outside your home, it must be provided for your dependent who is under age 13 and whom you claim as a dependent on your tax return or for another "qualifying dependent" who regularly spends at least eight hours per day in your household. If the expenses are incurred for services provided by a dependent care center (a facility that provides care for a fee and cares for more than six individuals not residing at the facility), the center must comply with all applicable state and local licensing and other legal requirements.

The Plan Administrator will provide you with additional guidance regarding the Dependent Care Spending eligibility requirements.

Childcare Subsidy Program

If you have a gross annual income of $99,000 or less, you may be eligible to participate in the Childcare Subsidy Program. The maximum available subsidy is $250 per month for eligible employees with a gross annual income of $63,000 or less; $175 per month for eligible employees with a gross annual income of $63,000.01 to $99,000. Qualifying dependents are Children under age 13, or qualified disability dependent children age 13-25, whom you claim as dependents for income tax purposes.

NOTE: *The maximum amount of your Dependent Care Spending Account (which is your Dependent Care FSA contribution plus the Childcare Subsidy amount) cannot be greater than $7,500 per Plan Year*[13].

The subsidy is available the first of each month. Your own contribution will become available approximately three days after your paycheck deduction. Please note that you will not be allowed to withdraw more than what is in your account at any given time.

This Childcare Subsidy program does not provide a subsidy for Elder Care. However, Elder Care for “qualifying dependents” is an eligible expense under the Dependent Care Spending Account. Please see the section listed above titled “Dependents Eligible for Care” for a description of qualifying dependents.

The Childcare Subsidy benefit is a per Household/Family benefit. If two Employees are married and have eligible Childcare costs, then only one Employee can enroll for the Childcare Subsidy Program.

[13] *The IRS limit is $7,500 per calendar year. This is an IRS Regulation and not a rule that T-Mobile can change.*

Reimbursement Procedures

Claims for reimbursement can be made through the MyChoice Account on the benefits website www.t-mobilebenefits.com or the MyChoice Mobile App. For additional claim filing options, contact the Benefits Center at **1-855-866-2367** (M-F, 5am – 5pm PT).

Timeframe to Incur and Submit Claims of Reimbursable Expenses

Unlike the Health Care Spending Account, only qualified expenses incurred during the plan year can be applied to your current plan year election. Claims should be submitted within a reasonable time of incurring the expense. However, you will have 120 days from the end of the plan year to submit expenses for the current plan year. As a result, the deadline to request reimbursement for qualified dependent care expenses for the plan year ending December 31st will be April 30th of each year.

Account Balance Exceeds Reimbursable Expenses

If there is money in your account at the end of the Plan Year and you have no more reimbursable expenses, IRS rules require that the money in your account be forfeited. In general, forfeited amounts will be used to pay Plan administrative costs. For this reason, you need to make conservative estimates of your reimbursable expenses for the coming Plan Year when you make your Dependent Care Spending Account election. As noted above, you have up to 120 days after the end of each Plan Year in which to file claims for expenses incurred during the Plan Year.

DCSA vs. Tax Credit

Often your federal, state (where eligible,) and Social Security tax savings provide greater tax benefits than using the federal tax credit. Since individual tax situations vary, it is important for you to select which approach offers more favorable tax savings. Contributions to the Dependent Care Spending Account reduce your federal tax credit availability. You may combine the Dependent Care Spending Account with the tax credit availability amount to a maximum of $3,000 for one dependent and $6,000 for two or more dependents.

Summary Plan Description for Medical, Dental, Vision, Section 125 Flexible Spending Account (FSA) Plans, and Group Short Term Disability

Name of Plan:

T-Mobile USA, Inc. Employee Benefit Plan

Name and Address of Employer who is the Plan Sponsor:

T-Mobile USA, Inc.
12920 SE 38th Street
Bellevue, Washington 98006

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated to other entities one or more fiduciary responsibility with respect to the Plan.

Agent for Legal Process:

The Plan Sponsor named above.

Employer Tax ID#:

91-1983600

Plan Number (PN):

506

Effective Date of Plan:

June 1, 2002

Type of Plan:

Group Health Care Coverage Plan, a Cafeteria Plan (Premium Payment Account; Health Care Spending Account; Dependent Care Spending Account), and a Welfare Benefit Plan providing Group Short Term Disability.

Plan Administrator:

The Plan Sponsor named above.

Telephone Number of Plan Administrator:

1-800-318-9270

Claims Administration — General Information:

The Plan Administrator has delegated claims administration to the Claims Administrators listed below. The relevant Claims Administrator has the full power and sole discretionary authority to interpret and apply the terms of the Plan as they relate to the applicable benefits and has final responsibility for determining the amount of any benefits payable and providing the claims procedures to be followed and the claims forms to be used. Any construction of the terms of the Plan for which there is a rational basis that is adopted by the relevant Claims Administrator shall be final and legally binding on all parties, and subject to review only if that interpretation or other action is arbitrary, capricious, or otherwise an abuse of discretion. Any review of

a final decision or action of that Claims Administrator will be based only on such evidence presented to or considered by the Claims Administrator at the time it made the decision that is the subject of the review. All participants in the Plan consent to actions of the applicable Claims Administrator made in its sole discretion and agree to the narrow standard of review described in this section. The Claims Administrators are the "appropriate named fiduciaries" of the Plan for purposes of claims administration, denial and/or review of denied claims under the Plan with respect to claims for benefits, as appropriate. In exercising their fiduciary responsibility, the Claims Administrators have discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe the terms of the Plan with respect to benefits. T-Mobile retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Medical Claims Administrator and Medical Claim Fiduciary:

United HealthCare Services, Inc.

9900 Bren Road East
Minnetonka, MN 55343

Phone: 1-877-259-1527

Premera Blue Cross

7001 220th St. S.W.
Mountlake Terrace, WA 98111

Phone: 1-866-358-2300

Bind Benefits, Inc., DBA Surest

P.O. Box 211758
Eagan, MN 55121

The Claims Administrators shall not be deemed or construed as an employer for any purpose with respect to the administrator or provision of Benefits under the Plan. The Claims Administrators shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

Prescription Drug (Rx) Claims Administrator and Rx Claim Fiduciary:

CVS Caremark

CVS Corporation
Customer Relations
One CVS Drive
Woonsocket, RI 02895

The Claims Administrators shall not be deemed or construed as an employer for any purpose with respect to the administrator or provision of Benefits under the Plan. The Claims Administrators shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

Type of Administration:

The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a Provider Network established by United HealthCare Services, Inc. (UHC), Bind Benefits, Inc., DBA Surest (Surest), Premera Blue Cross (Premera), and CVS Corporation (CVS).

Premera Blue Cross (Premera), Bind Benefits, Inc., DBA Surest (Surest) and UnitedHealthcare (UHC) are the "appropriate named fiduciary" of the Plan for purposes of claims administration, denial and/or review of denied claims under the Plan with respect to medical claims under either the Premera medical plan offering, Surest medical plan offering, or UHC medical plan offering, as appropriate. In exercising their fiduciary responsibility, Premera, Surest, and UHC have discretionary authority to

determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe the terms of the Plan with respect to medical benefits. T-Mobile retains sole and complete authority to determine eligibility of persons to participate in the Plan.

CVS Corporation is the "appropriate named fiduciary" of the Plan for purposes of claims administration, denial and/or review of denied claims under the Plan with respect to prescription drug (Rx) claims under either the Premera medical plan offering, Surest medical plan offering, or UHC medical plan offering, as appropriate. In exercising their fiduciary responsibility, CVS Corporation has discretionary authority to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe the terms of the Plan with respect to prescription drug (Rx) benefits. T-Mobile retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Dental Claims Administrator:

Delta Dental of Washington

P.O. Box 75893
Seattle, WA 98175-0983

Phone: 1-800-554-1907

Type of Administration:

The Plan is administered on behalf of the Plan Administrator by Delta Dental of Washington. The benefits are paid from funds provided by the Employer on behalf of the Plan in accordance with a contract with Delta Dental of Washington. Washington Dental Service is the Claims Administrator.

Vision Claims Administrator:

Vision Service Plan

P.O. Box 495933
Cincinnati, OH 45249

Phone: 1-800-877-7195

Type of Administration:

The Plan is administered on behalf of the Plan Administrator by Vision Service Plan. The benefits are paid from funds provided by the Employer on behalf of the Plan in accordance with a contract with Vision Service Plan. Vision Service Plan is the Claims Administrator.

Flexible Spending Account (FSA) Claims Administrator:

MyChoice Account

MSC 345475

P.O. Box 105168
Atlanta, GA 30348-5168

Phone: 1-855-866-2367

Type of Administration:

The Plan is administered on behalf of the Plan Administrator by MyChoice Account.

Short Term Disability Claims Administrator:

Broadspire Services, Inc.
PO BOX 14773
Lexington KY 40512

Phone: 1-877-222-8705

Type of Administration:

The Plan is administered on behalf of the Plan Administrator by Broadspire Services, Inc. The benefits are paid from funds provided by the Employer on behalf of the Plan in accordance with a contract with Broadspire Services, Inc. Broadspire Services, Inc. is the Claims Administrator.

Source of Contribution under the Plan:

There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of Calculating the Amount of Contribution:

Employee required contributions to the Plan Sponsor are the Employee's share of costs as determined by the Plan Sponsor. From time to time the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to Employees.

Date of the End of the Year for Purposes of Maintaining Plan's Fiscal Records:

Plan year shall be a twelve-month period ending December 31.

Determination of Qualified Medical Child Support Orders:

If an Employee is required by a medical child support order to provide coverage for their Children, these Children can be enrolled as timely enrollees as required by OBRA 93. Any child support order received will be subject to the Plan's procedures for determining the qualified nature of the order. The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator. Once a medical child support order is determined to be qualified and the dependent is enrolled, Employee may also enroll as a timely enrollee at the same time if not already covered under the Plan.

Employees may request a copy of the qualified medical child support from the Plan Administrator. To request a copy, please call **1-855-TMO-BENS** (**1-855-866-2367**) and ask to be transferred to the Qualified Order Specialist Team.

Amendment and Termination of the Plan:

Although the Plan Sponsor currently intends to continue the benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw, or add benefits or terminate the Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of the change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or person to who such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a copy of the Plan's Qualified Medical Child Support Order (QMCSO) procedures from the Plan Administrator, free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the internal claims procedures available to you under the Plan (discussed in the claims and appeals sections above), you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you

should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.