T-Mobile USA, Inc. Employee Benefit Plan

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

Insurance Certificates for Long Term Disability, Basic Life and Voluntary Life Plans

Insurance Certificate for Group Business Travel Accident Insurance and Global Travel Coverage

Effective January 1, 2024

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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 (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 2024)

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**.

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 share information as we:

- 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 share your information as we:

- 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 the law
- 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

Effective Date of this notice: January 1, 2023.

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:	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:	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
CVS Rx (UHC and Premera)	1-844-757-0417
Livongo	1-800-945-4355
Your Spending 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.

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 Your Benefits Resources 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, Annual 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.

Employee Assistance Program (LiveMagenta)

- Enrollment Requirements do not apply to the Employee Assistance Program (EAP).
- 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 be covered by the EAP.

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 30th day after 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 August 31.

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

The Employer designates the Annual 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 Annual 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 Annual 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 the 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 within 31 days 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 within the 30 days following August 1. In this example, you will need to enroll no later than August 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**—Life insurance coverage is automatic and begins on your first day of employment as an Eligible Employee. Employee contributions are not required for life 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 31 days of the Employee's initial eligibility date.

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**. 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 within 31 days of becoming eligible to participate. If you enroll within 31 days of 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 Annual 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 Annual Enrollment Period. You must enroll by the last day of the Annual 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 Annual Enrollment Period, you may not enroll in an FSA Plan until the next Annual 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 Annual 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 Your Benefits Resources 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 Annual 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 Your Benefits Resources 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.

Special Provision for CARES Act: On May 4, 2020, the U.S. Departments of Labor and the Treasury issued guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment, and claims/appeals. To protect individuals from losing benefits, the agencies are adjusting deadlines that may be missed during the "Outbreak Period," which is defined as the period beginning March 1, 2020, and ending a period of time 60 days after the end of the National Emergency, which has yet to be announced.

If you wish to make a change to your elections, it is your responsibility to access Your Benefits Resources at **http://www.t-mobilebenefits.com** or call the T-Mobile Benefits Center at 1-855-TMO-BENS (1-855-866-2367) to request a change due to the CARES Act special provision.

For purposes of the deadlines specified below, the clock is stopped during the "Outbreak Period," which extends from March 1, 2020, until 60 days after the end of the declaration of a National Emergency. Any days attributable to the deadline after the Outbreak Period ends will count towards the deadline, but days before and during the Outbreak Period are excluded for purposes of calculating the deadlines described below.

Deadlines subject this extension:

- 60-day deadline for notifying the plan administrator of the occurrence of a COBRA-qualifying event (e.g., divorce)
- 60-day deadline for notifying the plan of a determination of disability
- 60-day deadline for electing COBRA coverage
- 45-day deadline for paying first premium payment and 30-day deadline for paying subsequent premium payments*

* ***NOTE:*** *It's important to know that your premium payments are not waived. Instead, you are just given more time to make the payment before coverage is dropped.*

- Mid-Year enrollment under HIPAA:
  - Enrollment period triggered when eligible employees or dependents lose group health coverage or when an employee acquires a dependent through marriage, birth, or adoption
  - Enrollment period triggered when eligible employees or dependents lose Medicaid or CHIP coverage, or when eligible employees or dependents become eligible for state premium assistance subsidy through Medicaid or CHIP**

** ***NOTE:*** *This change will give you more time to enroll in your medical, including prescription drug, coverage as a result of a delay during the Outbreak Period, but you will still have to make your contributions for that period of coverage.*

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
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 plan[2]	Enroll in plan, or change contribution[3]	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 Annual Enrollment Period.*

[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 a Dependent dies	You must delete Dependent	Decrease or cease contribution[3]	Decrease or cease contribution
If there is a significant change to your employed Spouse's health plan	You may add or delete Dependent[2]	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 Dependent[2]	No change	No change
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

[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.*

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 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
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

[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.

[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
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
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

Type of Change	Effective Date of Change	Documentation Required	Dependent Verification
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

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):

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

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. 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 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.

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 0758
Carol Stream, IL 60132-0758

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 $500 will carry over to the next Plan Year. Amounts above $500 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) 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)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
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 reasonable and customary (R&C) rate; and/or expenses associated with non-covered services do not apply to the deductible.)	Benefits with copayments are **not subject** to deductibles, with the exception of the Emergency Care benefit. $750 individual $1,500 family	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		$2,250 individual $4,500 family	The family deductible must be met before the plan coinsurance applies for those with enrolled dependents. $2,250 individual $4,500 family
Copayments ▪ Copayments **apply** toward the Plan Year Maximum. ▪ The PCP copay applies to family practitioners, general practitioners, pediatricians, ARNP's, PA's, OBGYN's and internists.	PCP—$20 office visit Specialist—$30 office visit $30 urgent care center $200 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	Not applicable	Not applicable

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
Coinsurance ▪ Medical coinsurance applies to Plan Year Maximum.	100% after applicable copayment for most office visits 80% after deductible for most other services	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	80% after deductible for most services	80% after deductible for most services
Plan Year Maximum (excluding Deductibles) The Maximum **excludes** the following, which continue even after the maximum is met: ▪ Deductibles ▪ Amounts above R&C ▪ Prior authorization penalty (see "Prior Authorization Requirement")	$3,000 individual $6,000 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		$2,000 individual $4,000 family	$2,000 individual $4,000 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")	$3,750 individual $7,500 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		$4,250 individual $8,500 family	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
Lifetime Maximum Benefit	Limit does not apply.						
Coordination of Benefits	Regular coordination of benefits (come out whole approach). Birthday rule applies.						
Pre-existing Conditions	No pre-existing condition limitation.						
Prior Authorization Requirement Services requiring prior authorization include:	Check with Plan	Check with Plan	Check with Plan	Check with Plan	Check with Plan	Check with Plan	Check with Plan

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
For UHC Plan: In network providers are responsible for obtaining prior authorization on your behalf, some exceptions apply—please check with Plan for additional details on requirements:	▪ Non-Emergency Air Ambulance Services ▪ Clinical Trials / ALL ▪ Cochlear Implants / ALL ▪ Congenital Heart Disease Surgery ▪ Gender Dysphoria – Surgery and certain non-surgical treatments ▪ All inpatient admissions (except maternity) including acute hospital, rehabilitation facilities, skilled nursing facilities and hospice. All home-based services, including nursing services, respiratory, speech, physical and occupational therapies and IV infusion services. ▪ Diabetes Insulin pump greater than $1,000 ▪ 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). "This SPD is only a summary of services that may be covered under the Plan. Certain services may require additional criteria be met before approval of coverage. T-Mobile has delegated to the Claims Administrators the discretion and authority to decide whether a service or supply is a covered health service or supply. Where this SPD is silent, the Plan is administered according to the Claims Administrators' standard coverage policies and standard guidelines. Please contact the Plan for more information regarding specific required criteria for a covered service.						
For Premera 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. ▪ Radiotherapy, including proton beam. ▪ 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. "This SPD is only a summary of services that may be covered under the Plan. Certain services may require additional criteria be met before approval of coverage. T-Mobile has delegated to the Claims Administrators the discretion and authority to decide whether a service or supply is a covered health service or supply. Where this SPD is silent, the Plan is administered according to the Claims Administrators' standard coverage policies and standard guidelines. Please contact the Plan for more information regarding specific required criteria for a covered service.						
UHC Plan 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 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 Plan Only: 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 ▪ Finding community resources ▪ To learn more about the personal health support programs, contact customer service at 1-866-358-2300.						

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	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
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 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). ▪ 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 medical administrator's section of this SPD.	PCP—100% after $20 copay Specialist—100% after $30 copay **Testing and Treatment** 80%, no deductible (Naturopaths covered out of network)	PCP—100% after $35 copay Specialist—100% after $50 copay **Testing and Treatment** 80%, no deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
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	**Initial Office Visit** PCP—100% after $20 copay Specialist—100% after $30 copay **Global Obstetrical Care** 80% after deductible	**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	80% after deductible	80% after deductible

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	No out-of-network benefits are available.	*IN-NETWORK*	*OUT-OF-NETWORK*	*IN-NETWORK*	*OUT-OF-NETWORK*	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
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.							
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 **<u>not</u>** 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.	**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	**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	80% after deductible Inpatient well newborn is not subject to deductible	80% after deductible Inpatient well newborn is subject to deductible
Preventive Care ▪ Well-child care from birth through age 17. No pre-set examination schedule. At physician's discretion. ▪ One routine exam allowed each plan year for adults in addition to one well-women exam per plan year. ▪ Includes immunizations for children and adults. ▪ One prostate exam allowed each plan year, plus associated lab work. ▪ One Pap smear per plan year. ▪ Routine mammograms allowed once per plan year—schedule set at physician's discretion, not by age.	**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	**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	**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	**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	**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	**Office Visit / Prostate Exam** 100%, no deductible **Annual Flu Shot** 100%, no deductible **Routine Mammogram** 100%, no deductible **Breast Pumps** 100%, no deductible	**Office Visit / Prostate Exam** 100%, no deductible **Annual Flu Shot** 100%, no deductible **Routine Mammogram** 100%, no deductible **Breast Pumps** 100%, no deductible

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	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
▪ One routine hearing exam per plan year.							
Prescription Drug Coverage							
▪ Rx coverage provided by CVS ▪ Includes coverage for oral contraceptives, Depo-Provera, and Norplant. ▪ Retail—Limited to a 30-day supply or 90-day supply ▪ Mail Order—Limited to a 90-day supply. ▪ Drugs for erectile dysfunction and hair loss are not covered. ▪ Smoking cessation medications are covered; copays are waived for prescription drugs related to smoking cessation. ▪ Tier 2 medications for blood pressure, cholesterol, diabetic oral medication, and supplies are covered subject to a $15 copay (retail); $30 copay (mail order) except for HSA plans. ▪ Tier 1 = Your Lowest Cost Option. ▪ Tier 2 = Your Mid-Range Cost Option. ▪ Tier 3 = Your Highest Cost Option. ▪ You are not responsible for paying a copayment and/or coinsurance for preventive care medications. Benefits for Preventive care medications are not subject to payment of the annual deductible.	**Retail (30 days)** Tier 1 (Generic): $ 10 copay Tier 2 (Preferred): $35 copay Tier 3 (Non-Preferred): $60 copay Tier 4 (Specialty): $0 copay if enrolled in Prudent Rx; 30% coinsurance if not enrolled in Prudent Rx; For non-Prudent Rx specialty drug, copay capped at $60 maximum **Mail Order / Retail (90 days)** Tier 1 (Generic): $20 copay Tier 2 (Preferred): $70 copay Tier 3 (Non-Preferred): $120 copay	**Retail (30 days)** Tier 1 (Generic): 10% ($5 copay minimum / $20 copay maximum) Tier 2 (Preferred): 20% ($25 copay minimum / $55 copay maximum) Tier 3 (Non-Preferred): 30% ($45 copay minimum / $80 copay maximum) Tier 4 (Specialty): $0 copay if enrolled in Prudent Rx; 30% coinsurance if not enrolled in Prudent Rx; For non-Prudent Rx specialty drug, copay capped at $80 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)	**Retail and Mail Order** Not covered	**Retail (30 days)** All tiers: 80% after deductible **Mail Order (90 days)** All tiers: 80% after deductible	**Retail and Mail Order** Not covered	**Retail (30 days)** Tier 1 (Generic): 10% ($5 copay minimum / $20 copay maximum) Tier 2 (Preferred): 20% ($25 copay minimum / $55 copay maximum) Tier 3 (Non-Preferred): 30% ($45 copay minimum / $80 copay maximum) Tier 4 (Specialty): $0 copay if enrolled in Prudent Rx; 30% coinsurance if not enrolled in Prudent Rx; For non-Prudent Rx specialty drug, copay capped at $80 **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)	**Retail (30 days)** All tiers: 80% after deductible **Mail Order (90 days)** All tiers: 80% after deductible
Hospital Services							

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
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 under the respective medical administrator's section of this SPD.	80% after $200 copay and deductible (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 deductible	80% after deductible
Inpatient Care ▪ Includes semi-private room and board, and physician and ancillary services. ▪ Inpatient physical therapy, radiation therapy, chemotherapy, hemodialysis treatment.	80% after deductible	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 Prior authorization required for confinement, extension of planned confinement and surgery.	80% after deductible Prior authorization required for confinement, extension of planned confinement and surgery.
Birthing Centers ▪ Includes semi-private room and board and ancillary services.	80% after deductible	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 Prior authorization required for confinement, extension of planned confinement and surgery.	80% after deductible Prior authorization required for confinement, extension of planned confinement and surgery.
Mental Health / Substance Abuse Benefits							
▪ LiveMagenta Employee Assistance Program (EAP)—Up to ten EAP visits for each covered member provided at no cost per concern per plan year.							
Inpatient Mental Health	80% after deductible	80% after deductible	60% after deductible Prior authorization required for confinement, extension of	80% after deductible	60% after deductible Prior authorization required for confinement, extension of	80% after deductible Prior authorization required for confinement, extension of	80% after deductible Prior authorization required for confinement, extension of

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
			planned confinement.		planned confinement.	planned confinement.	planned confinement.
Outpatient Mental Health	100% after $20 copay	100% after $35 copay	Office visit: 100% after $35 copay	80% after deductible	60% after deductible	80% no deductible	80% after deductible
Inpatient Substance Abuse	80% after deductible	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 Prior authorization required for confinement, extension of planned confinement.	80% after deductible Prior authorization required for confinement, extension of planned confinement.
Virtual Behavioral Health Therapy and Coaching (AbleTo Therapy360 Program) ▪ **UHC Only:** Services must be received by a Designated Network Provider.	100%	100%	Not covered	100% after you meet the annual deductible; benefits for the initial consultation will be paid at 100%	Not covered	100%	100% after you meet the annual deductible; benefits for the initial consultation will be paid at 100%
Outpatient Substance Abuse	100% after $20 copay	100% after $35 copay	Office visit: 100% after $35 copay	80% after deductible	60% after deductible	80%, no deductible	80% after deductible
Partial Hospitalization	80%, no deductible	80%, no deductible	60%, no deductible	80% after deductible	60% after deductible	80%, no deductible	80% after deductible
Intensive Outpatient Care	80%, no deductible	80%, no deductible	60%, no deductible	80% after deductible	60% after deductible	80%, no deductible	80% after deductible
All Other Covered Services (in alphabetical order)							
Acupuncture ▪ Limited to 30 visits each plan year.	100% after $30 copay (out-of-network providers are covered)	100% after $50 copay	100% after $50 copay	80% after deductible	80% after deductible	100% after deductible	80% after deductible
Allergy, Testing, and Treatment ▪ Coverage for diagnosis and treatment in a doctor's office.	**Office Visit** PCP: 100% after $20 copay Specialist: 100% after $30 copay **Allergy Testing and Treatment** 80%, no deductible	**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	80%, no deductible	80% after deductible
Ambulance (including Air Ambulance) ▪ For life threatening conditions. ▪ For situations in which the patient would be endangered if this	100%, no deductible (out-of-network providers are covered)	100%, no deductible		100% after deductible		100%, no deductible	100% after deductible

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
benefit was not utilized. ▪ Eligible Expenses or Allowed Amounts for Ground or Air Ambulance transport provided by a non-Network provider will be determined as described in the medical administrators' section of this SPD							
Chiropractic ▪ Limited to 30 visits each plan year.	100% after $30 copay (out-of-network providers are covered)	100% after $50 copay	100% after $50 copay	80% after deductible	80% after deductible	100% after deductible	80% after deductible
Disposable Medical Supplies	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% 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 services are covered as any other medical condition. ▪ Speech aid devices and tracheoesophageal voice devices only after completing a required 3-month rental period.	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
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.	**Office Visit** PCP: 100% after $20 copay Specialist: 100% after $30 copay	**Office Visit** PCP: 100% after $35 copay Specialist: 100% after $50 copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
▪ Reversals of voluntary sterilization are not 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 for details	**Inpatient / Outpatient Services:** 80% after deductible	**Inpatient / Outpatient Services** 80% after deductible					
Gender Affirming Care ▪ Diagnosis and treatment are both covered. ▪ Travel & Lodging available; see Travel & Lodging section for details	**Office Visit** PCP: 100% after $20 copay Specialist: 100% after $30 copay **Inpatient / Outpatient Services** 80% after deductible	**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	80% after deductible	80% after deductible
Hearing Aids ▪ Limited to $6,000 every three years.	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% 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).	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
Hospice ▪ Bereavement counseling for family members provided under the EAP plan, not the medical plan. ▪ No dollar or day limits. ▪ Patient must have life expectancy of 6 months or less.	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
Infertility Benefits ▪ Fertility treatments are administered through Progyny. Please call (833) 281-0076 to activate benefits	**Office Visit** PCP: 100% after $20 copay Specialist: 100% after $30 copay	**Office Visit** PCP: 100% after $35 copay Specialist: 100% after $50 copay	Not covered out of network	80% after deductible	Not covered out of network	80% after deductible	80% after deductible

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
▪ Diagnosis and treatment are both covered.	**Inpatient / Outpatient Services** 80% after deductible	**Inpatient / Outpatient Services** 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.	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
Inpatient Radiologist, Anesthesiologist, Pathologist and Laboratory (RAPs)	80% after deductible (out-of-network providers are covered)	80% after deductible		80% after deductible		80% after deductible	80% after deductible
Licensed Naturopath ▪ No coverage for supplements. ▪ Limited to 30 visits each plan year.	100% after $30 copay	100% after $50 copay	100% after $50 copay	80% after deductible	80% deductible	100% after deductible	80% after deductible
Mammogram ▪ Due to medical diagnosis. ▪ Routine mammograms are covered under Preventive Care.	**Office Visit** PCP: 100% after $20 copay Specialist: 100% after $30 copay **Outpatient** 80%, no deductible	**Office Visit** PCP: 100% after $35 copay Specialist: 100% after $50 copay **Outpatient** 80%, no deductible		**Office Visit / Outpatient** 80%, after deductible		80%, no deductible	80% after deductible
Nutritional Counseling ▪ Must be provided by dietician or nutritional counselor. ▪ Covered for chronic diseases only.	100% after $30 copay	100% after $50 copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
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	80% after deductible	80% after deductible		80% after deductible		80% after deductible	80% after deductible

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
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.							
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 for details ▪ Member will be required to complete a pre-surgery psychological evaluation to include a clinical interview and objective diagnostic testing. The use of objective psychological assessment instruments is strongly recommended by the American Society for Bariatric Surgery and required by UHC as part of the assessment.	80% after deductible Please refer to details in Covered Services & Supplies section for coverage requirements	80% after deductible Please contact your carrier for additional requirements.	Not covered	80% after deductible Please contact your carrier for additional requirements.	Not covered	80% after deductible Please contact your carrier for additional requirements.	80% after deductible Please contact your carrier for additional requirements.
Outpatient Hospital Radiation Therapy	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
Outpatient Lab / X-Ray Services	80%, no deductible (out-of-network	80%, no deductible		80% after deductible		80%, no deductible	80% after deductible

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
	providers are covered)						
Outpatient Surgery (at outpatient facility)	80% after deductible	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 Prior authorization is required for certain outpatient procedures.	80% after deductible Prior authorization is required for certain outpatient procedures.
Outpatient Surgery (at physician's office)	PCP: 100% after $20 copay Specialist: 100% after $30 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.	80% after deductible Prior authorization is required for certain outpatient procedures.	80% after deductible Prior authorization is required for certain outpatient procedures.
Outpatient Therapies ▪ Physical therapy (60 visits combined with OT). ▪ Occupational therapy (60 visits combined with PT). ▪ Speech therapy (60 visits/plan year max). ▪ Physical, Occupational, and Speech therapy provide a combined maximum of 120 visits per plan year for congenital anomalies, developmental delay, cerebral palsy, and hearing impairment. ▪ Physical, Occupational, and Speech therapy, provide unlimited visits for autism.	100% after $30 copay	100% after $50 copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
Private Duty Nursing (Outpatient Only)	80% after deductible	80% after deductible	60% after deductible	80% of after deductible	60% after deductible	80% 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.	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible
Temporomandibular Joint Disorder (TMJ)	**Office Visit** PCP: 100% after $20 copay	**Office Visit** PCP: 100% after $35 copay	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan** *No out-of-network benefits are available.*	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
		IN-NETWORK	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
▪ Dental services are not covered under Medical Plan (see separate benefit under Dental Plan).	Specialist: 100% after $30 copay **Inpatient / Outpatient Services** 80% after deductible	Specialist: 100% after $50 copay **Inpatient / Outpatient Services** 80% after deductible					
Transplants ▪ For both UHC and Premera, travel and lodging available; see Travel and Lodging section for details ▪ **Premera Only:** An Approved Transplant Center, this is a hospital or other provider that's developed expertise in performing organ transplants and meets other approval standards we use. If none of our centers or the approved transplant centers can provide the type of transplant you need, this benefit will cover a transplant center that meets the written approval standards we follow. ▪ **UHC 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.	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.	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, plan pays 80% 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, plan pays 80% after deductible. No travel benefits.
Urgent Care Center	**Office Visit** 100% after $30 copay **Outpatient Services**	**Office Visit** 100% after $50 copay All other covered expenses billed by the urgent	60% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible

Premera (Group #4022154) **UHC (Group #222244)**	**Exclusive Provider Organization (EPO) Plan**	**Health Reimbursement Account (HRA) Plan**		**Health Savings Account (HSA) Plan**		**HRA Out-of-Area Plan**	**HSA Out-of-Area Plan**
	No out-of-network benefits are available.	***IN-NETWORK***	***OUT-OF-NETWORK***	***IN-NETWORK***	***OUT-OF-NETWORK***	***ONLY** available to employees **Identified** as living outside Medical Plan service area.*	
	80% after deductible Non-network urgent care will be covered same as in-network.	care center at 80%, no 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.	100%	100%	Not covered	80% after deductible	Not covered	100%	80% after deductible

With Teladoc, 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. Teladoc is free for all T-Mobile members enrolled with UHC. UHC Members: Go to www.myuhc.com/virtualvisits.

Premera Members have access to Doctor on Demand. Video chat with a doctor for urgent care when you're sick, or for preventive health and chronic conditions care. What it's for: Cold and flu symptoms, pediatric issues, child development, skin conditions, allergies, headaches, diet and nutrition and medication management.

Premera Members also have access to 98point6. An on-demand, 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 on-line provider directory: http://www.myuhc.com

Prior Authorization

There are two requirements of the prior authorization process under this Plan. The type of prior authorization process depends upon what type of medical care a Covered Person needs. The two types of prior authorization processes are:

- Choice Network Provider—Network Benefits for services listed under Prior Authorization Requirement (see **Medical Benefits Summary**).
- UnitedHealthcare (UHC)—Mental Disorder or Substance Use Disorder Treatment. (Discussed under **Mental Health / Substance-Related and Addictive Disorders Summary)**.

Prior Authorization Requirement

The Network Provider starts the prior authorization process for all medical care other than for Mental Disorder or Substance Use Disorder Treatment and services outlined in Personal Health Support section. For all other services, **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.

This Plan pays Mental Disorder and Substance Use Disorder Treatment at the Network level, as shown in the **Mental Health / Substance Use Disorder Benefits Summary**.

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 Facilities and Other Providers

If you have a medical condition that Personal Health Support (see Personal Health Support section) believes needs special services, they may direct you to a Designated Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support may direct you to a non-Network facility or provider.

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

Benefits for Health Services from Non-Network Providers

When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, 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 UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare 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.

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.

Non-Network Providers Paid at Network Percentage Level

Non-Network providers are not contracted with UHC to accept contracted rates. 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.

When you receive Covered Health Services through a Network Physician, we will pay Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

- Radiology, anesthesiology, pathology services, are paid at the Network level if services are initiated at a Network Facility. Services must be given in one of the settings shown below:
  - Inpatient Hospital.
  - Outpatient facility, which is part of a Hospital.
  - Ambulatory Surgical Center.
  - Independently billed Outpatient Lab and X-Ray (services not billed in conjunction with a non-network provider office visit.)

- Emergency Care. Emergency Care is payable at the Network level, even if services are received from a Non-Network Provider.
- Naturopathic Physicians.
- Acupuncturists.
- Chiropractors.

In addition, if specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify Personal Health Support (see Personal Health Support section) and they will work with you and your Network Physician to coordinate care through a non-Network Provider.

When you receive Covered Health Services through a Network Physician, we will pay Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

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.

Non-Network Benefits

Eligible Expenses are based on either of the following:

When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

- Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates, or subcontractors, at the Claims Administrator's discretion.

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

This Plan pays the Non-Network percentage of Eligible Expenses as shown in the **Medical Benefits Summary** for Non-Network Provider services.

See the **Medical Benefits Summary** for a complete description of the deductibles that apply under this Plan.

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.

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: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. 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.

Personal Health Support

This plan required the use of Personal Health Support. Please see the **Personal Health Support** 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

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.

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.

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

UHC REQUIRES PRIOR AUTHORIZATION FOR CERTAIN COVERED HEALTH SERVICES. NETWORK PRIMARY PHYSICIAN AND OTHER NETWORK PROVIDERS ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION BEFORE THEY PROVIDE THESE SERVICES TO YOU.

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

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 from Non-Network Providers That Require Prior Authorization

You are required to obtain prior authorization for the following services obtained from non-network providers:

- **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 and sleep studies, you must obtain prior authorization from the Claims Administrator 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) 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; Intensive Outpatient Treatment 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 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.

Network providers are responsible for obtaining prior authorization from UHC before they provide certain services to you.

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;
- End Stage Renal Disease services;
- Blepharoplasty (upper eye lid surgery);
- Breast Reconstruction, other than surgery following treatment for cancer (mastectomy);
- Breast Reduction; and
- Ligation (vein stripping).

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 Network Facilities and Other Providers

If you have a medical condition that Personal Health Support believes needs special services, they may direct you to a Designated Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support may direct you to a non-Network facility or provider.

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

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)

Special Note Regarding Mental Health and Substance-Related and Addictive Disorders Services

You must obtain prior authorization from UnitedHealthcare (UHC) for services from out-of-network providers, as described below. In network providers will obtain prior authorization with UHC directly on your behalf.

When Benefits are provided for any of the services listed below, prior authorization is required:

- Mental Health Services—Inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); partial hospitalization/day treatment; intensive outpatient program treatment, outpatient electro-convulsive treatment; psychological testing and Transcranial Magnetic Stimulation.
- Neurobiological Disorders—Autism Spectrum Disorder Services—inpatient services (including services at a Residential Treatment Facility); partial hospitalization/day treatment; intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing and Intensive Behavior Therapy including Applied Behavioral Analysis (ABA) services.
- Substance-Related and Addictive Disorders Services—Inpatient services (including services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electroconvulsive treatment; psychological testing; Medication Assisted Treatment (MAT) for substance use disorder and Transitional Care.

For a scheduled admission out of network, you must obtain prior authorization from UHC prior to the admission, or as soon as reasonably possible for non-scheduled admissions.

Mental Health Services

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;
- Intensive Outpatient Treatment; and
- Outpatient treatment.

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.

Neurobiological Disorders—Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and/or property and/or impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the *Enhanced Autism Spectrum Disorder* benefit below.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations, assessment and treatment and/or procedures;
- Treatment planning;
- Referral services;
- Medication management;
- Individual, family, therapeutic group, and provider-based case management services;
- Crisis intervention;
- Partial Hospitalization / Day Treatment;
- Services at a Residential Treatment Facility;
- Intensive Outpatient Treatment; and
- Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Enhanced Autism Spectrum Disorder Benefits

Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

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.

Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator. Contact the Mental Health/Substance Use Disorder Administrator regarding Benefits for Neurobiological Disorders—Mental Health Services for Autism Spectrum Disorders.

Substance Related and Addictive Disorder Services

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 Treatment; and
- Outpatient treatment.

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 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.

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.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer, or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up to date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. 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.

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.

Mental Health / Substance Use Disorder Benefit Exclusions

- 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 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 the American Psychiatric Association.
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder and paraphilic disorders.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Mental Health / Substance Use Disorder Benefit Appeals

Pre-Service Appeals

Pre-service appeals fall within two categories, urgent and non-urgent. An urgent appeal is available for members when a clinical benefit determination has been made and the care is "urgent": when a delay in a treatment decision could potentially "place the patient's health or the health of others in serious jeopardy, significantly increase the risk to the patient's health, result in severe pain, or impact the patient's ability to regain maximum functioning."

The pre-service appeal process for urgent care must be completed no later than 72 hours after the request. UHC performs one level of urgent appeals. If a benefit determination decision is upheld through the UHC appeal process, the member has the option of a voluntary external review. UHC coordinates this voluntary review.

For pre-service claims that are not urgent, UHC provides a two-level process for post-service appeals. Each level is completed in 15 days.

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

Medical Benefits are payable for Eligible Expenses incurred by the Covered Person while covered under this Plan.

T-Mobile USA, Inc. has delegated to UHC 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 UHC determines that UHC will pay for Benefits.

For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UHC will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UHC's reimbursement policy guidelines, as described in this SPD.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UHC's contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as arranged by UHC, 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 UHC or an amount permitted by law. Please contact UHC if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or any deductible. The Plan will not pay these charges or amounts you are not legally obligated to pay.

In all other circumstances, when Covered Health Services are received from a non-Network provider, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UHC or one of UHC's vendors, affiliates, or subcontractors, at UHC's discretion.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section *2799B-2(d) of the Public Health Service Act*.

- When Covered Health Services are received from a Network provider, Eligible Expenses are UHC's contracted fee(s) with that provider.

Each Covered Person must satisfy certain Copayments and/or Deductibles before any payment is made for certain Covered Services and Supplies. Then the Medical Benefits pays the percentage of Eligible Expenses shown in the **Medical Benefits Summary**. This information is also available by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

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.

Non-Network Benefits

- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, 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.
- 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, 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)*.

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 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 Emergency Health Services 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 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.

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expense are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. 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.

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 1-877-259-1527and 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.

Covered Services and Supplies also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a course of treatment developed by UHC and authorized by the Employer as an alternative to the services and supplies that would otherwise have been considered Covered Services and Supplies.

Unless the ACP specifies otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments, and deductibles will apply to these services.

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;
- 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 or conditions.

Benefits are provided for a single unit of Durable Medical Equipment (example: one insulin pump or one glucose monitor) 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 $6,000 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.

Kaia Health

UnitedHealthcare has worked with Kaia Health to provide a mobile app for on-demand, personalized support to help relieve pain and live healthier.

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 co-morbid 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.

Nutritional Counseling

Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include:

- Diabetes mellitus;
- Coronary artery disease;
- Congestive heart failure;
- Severe obstructive airway disease;
- Gout;
- Renal failure;
- Phenylketonuria; and
- Hyperlipidemia.

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 18 or older;
- Completed and documented a 3-month supervised weight loss program prior to surgery;
- Have a BMI (body mass index) of 40 or greater; or have a minimum BMI of 35 with complicating co-morbidities (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 20 visits for each Employee or Dependent Spouse. Covered Services are limited to a lifetime maximum of 30 visits for each Dependent Child.

Physician Services

Covered Health Services include:

- Treatment of a Sickness or Injury;
- Preventive Care;
- Voluntary family planning;
- Well-baby and well-child care;
- 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;

  NOTE: *For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice communication and auditory processing only when the disorder results from injury, sickness, stroke, cancer, autism spectrum disorder, or a congenital anomaly, development delay, cerebral palsy, hearing impairment or is needed following the placement of a cochlear implant.*
- 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 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 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 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 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 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

- A per diem rate, up to $50.00 per day, for the Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

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.

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 for dependent child/children
- 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.

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.
- 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.*
- Medical, surgical, diagnostic, psychiatric, Substance Abuse Disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the medical claims administrator makes a determination regarding coverage in a particular case are determined to be:
  - Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use;
  - Subject to review and approval by any institutional review board for the proposed use;
  - The subject of an ongoing clinical trial that does not meet the definition of a Covered Health Service under Clinical Trials; or
  - A service that does not meet the definition of a Covered Health Service.
- If a Covered Person has a "life-threatening" Sickness or condition (one which is likely to cause death within one year of the request for treatment) the medical claims administrator may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the Sickness or condition. For this to take place, the medical claims administrator must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- Liposuction
- 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.
- Nutritional counseling unless medically prescribed. Non-disease specific, nutritional education such as general good eating habits, calorie control or dietary preferences (e.g., vegetarian, macro-biotic) is excluded from coverage.

  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.
- Services given by a pastoral counselor.
- 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
  - Required to obtain or maintain a license of any type.
- Private duty nursing services while confined in a facility.
- Psychosurgery (lobotomy).
- 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 mechanical or 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.
- Rest cures.
- Reversal of voluntary sterilization.
- 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 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 the American Psychiatric Association.
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
- 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.
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Transitional Living services.
- Non-Medical 24-Hour Withdrawal Management.
- High intensity 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.
- 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;
  - Biofeedback and bioenergetic therapy;
  - 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;
  - Sensory or auditory integration therapy;
  - Sleep therapy;
  - 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
  - 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.

- 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, WHILE COVERED UNDER A HIGH DEDUCTIBLE HEALTH PLAN. 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 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 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 monthly 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. For 2022, 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

Coverage Category	Per Pay Period Contribution to HSA
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 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 Annual Enrollment, you have the opportunity to review and change your benefit election. Any changes you make during Annual 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 for 2022:

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: 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.

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 be adjusted 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.

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. T-Mobile will remove $124.98 from the HRA plan, if the funds are still available, because the employee has no enrolled dependents as of October 1.

Reinstatement without a break in coverage. Following a termination, if you are rehired by T-Mobile USA, Inc., can you be reinstated without experiencing any break in coverage?

No—your HRA Plan does not allow reinstatement without experiencing any break in coverage. When you are rehired by T-Mobile USA, Inc. and re-enroll in the active medical plan and the HRA Plan, the HRA Contribution amount will equal the amount a newly hired active employee would be eligible for. (See this Section under the heading *Mid-Year Enrollment*.)

Reinstatement with a break in coverage. Are you able to recover funds after a break in employment?

No—you cannot use prior accumulated balances after re-enrollment as a result of a break in employment. When you are rehired by T-Mobile USA, Inc. and re-enroll in the active medical plan and the HRA Plan, the HRA Contribution amount will equal the amount a newly hired active employee would be eligible for. (See this Section under the heading *Mid-Year Enrollment*.)

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 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 HRA yearly 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 a 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 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 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. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)."

COBRA continuation coverage must be offered with respect to a participant's HRA when the Plan is subject to COBRA. If your employment terminates for any reason the funds in your HRA will revert back to us 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 IRS 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—an expense that you incur specific to health care 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 co-payments; 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).

The above information should be filed 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 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.

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.

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 Disorders

A group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

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, supplies, or Pharmaceutical Products, which UHC determines to be:

- 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;
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in this document; or
- Not otherwise excluded in this SPD.

Covered Family Members or Covered Person

The Employee and the Employee's Spouse, Domestic Partner (Common Law Spouse) 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 in order 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.

Designated Transplant Facility

A facility designated by UHC to render Covered Health Services and Supplies for Qualified Procedures under this Plan.

Designated United Resource Network Facility

A Hospital that UHC names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with UHC to render Covered Health Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility may or may not be located within our geographic area.

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 Care Services through live audio with video technology or audio only.

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 Section 3—*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.

When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, 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 UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare 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.

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

Experimental or Investigational Services—medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time UHC make 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 in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- 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); or
- The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials; or
- If you are not a participant in a qualifying clinical trial, as described in the Other Services and Supplies section, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, UHC 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, UHC 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 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 Treatment

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 of 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 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-Medical 24-Hour Withdrawal Management

An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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

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—treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility 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 approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator.

- 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.

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" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

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 of 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 of 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 Care

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.

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 that are not determined to be effective for treatment of the medical condition 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.

1) 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.)
2) 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.)

   UHC has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UHC 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**.

Please 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 Care 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

A facility 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.

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:

- N**etworks**. 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/T-Mobile** 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 primary care 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. Additionally, you may qualify for continuing care from non-primary care providers if you are in an "active relationship" or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy
- Are receiving treatment for a terminal illness

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. Please see ***Complaints and Appeals***.

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.

Benefits For Out-Of-Network Providers

The following covered services and supplies provided by out-of-network providers will always be covered:

- 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 located outside of 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. 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 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. (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 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" (please see the ***Allowed Amount*** subsection 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. 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 to 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 to 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 three 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.

  NOTE: *Ambulances are always paid based on billed charges.*

If applicable law requires a different allowed amount than the least of the three 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).

NOTE: *Non-contracted ambulances are always paid based on billed charges.*

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 (please see the ***Allowed Amount*** subsection 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 to the out-of-pocket maximum are:

- The calendar year deductible; and
- Coinsurance.

Expenses that do not apply to 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 three 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.

  NOTE: *Ambulances are always paid based on billed charges.*

If applicable law requires a different allowed amount than the least of the three 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).

NOTE: *Non-contracted ambulances are always paid based on billed charges.*

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. Please 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 primary care 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. Additionally, you may qualify for continuing care from non-primary care providers if you are in an "active relationship" or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy
- Are receiving treatment for a terminal illness

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. Please see ***Complaints and Appeals***.

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 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 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. (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 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 (please see the ***Allowed Amount*** subsection 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 to the out-of-pocket maximum are:

- Your coinsurance;
- The calendar year deductible; and
- Copays.

There are some exceptions. Expenses that do not apply to 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 three 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.

  NOTE: *Ambulances are always paid based on billed charges.*

If applicable law requires a different allowed amount than the least of the three 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).

NOTE: *Non-contracted ambulances are always paid based on billed charges.*

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). This Out-Of-Area Care section 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. Please 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. Please 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 Web site. 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 (please see the ***Definitions*** section 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" (please see the ***Definitions*** section 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 are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. 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. Please refer to the actual benefit provisions throughout this section and the ***Exclusions*** section 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 for dependent child/children
- 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 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 nonclinical 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
- 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

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
- 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 co-morbid 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 care services are subject to the same cost shares that you would pay for inpatient or outpatient treatment for other covered medical conditions, for all ages. To find the amounts you are responsible for, please see the Medical Benefits Summary.

Benefits are provided for all gender affirming care surgical services which meet the Premera medical policy, including facility and anesthesia charges related to the surgery. Our medical policies are available from customer service, or at www.premera.com/T-Mobile.

Benefits for gynecological, urologic and genital surgery for covered medical and surgical conditions, other than as part of gender affirming care, are covered under the surgical benefits applicable to those conditions.

NOTE: *Coverage of prescription drugs, and mental health treatment associated with gender reassignment surgery, 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
- 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 either the prescribing physician or audiologist
- 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 the ***Surgery*** and ***Rehabilitation Therapy*** benefits)

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
- Blood glucose monitor and supplies
- 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
- 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 (M.D. or D.O.). 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. Please see Medical Travel and Lodging section for details.

Facility Care

This benefit covers inpatient hospital, birthing center, 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:

- Prenatal care, 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 (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). 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. Please see the* ***Surgery*** *benefit for details on surgery coverage.*

Please 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:

- Oral nutrition or supplements not used to treat inborn errors of metabolism or any of the above listed conditions
- Specialized infant formulas
- Lactose-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.

- 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 Dysphoria (Gender Identity Disorder);
- 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.

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

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Travel and lodging costs are subject to the IRS limits in place on the date you had the expense. The mileage 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 assumed to be 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 (M.D. or D.O.) 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 (M.D. or D.O.)
- 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" (please see the ***Definitions*** section 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, speech and occupational 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 (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).*

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) are provided. Covered orthognathic surgery for repair of congenital (apparent at birth) deformities determined to be medically necessary will not apply to any annual maximum or lifetime limits of this plan 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 20 visits for each employee or dependent spouse. Benefits are limited to a lifetime maximum of 30 visits for each eligible dependent child.

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

For members who are 45 or older or who are under age 45 and at high risk for colorectal cancer. 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, please see the ***Surgery*** benefit.

For professional diagnostic services benefit information, please see the ***Diagnostic X-Ray, Lab, And Imaging*** benefit.

For home health or hospice care benefit information, please see the ***Home Health Care*** and ***Hospice Care*** benefits.

For preventive or routine services, please see the ***Preventive Care*** benefit.

For diagnosis and treatment of psychiatric conditions benefit information, please see the ***Mental Health Care*** benefit.

For diagnosis and treatment of temporomandibular joint (TMJ) disorders benefit information, please 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
- EEG biofeedback or neurofeedback services

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, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the ***Rehabilitation Therapy*** benefit.

See the ***Neurodevelopmental (Habilitation) Therapy*** benefit for physical, speech or occupational 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 or sterilization reversal
- 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
- Male sterilization/vasectomy

For organ, bone marrow or stem cell transplant procedure benefit information, please see the ***Transplants*** benefit.

For services to change gender, please 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 the "Definitions" section, 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 the ***Definitions*** section, 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. (Please see the ***Definitions*** section 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 the ***Definitions*** section 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. Please 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, please 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.

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 the three criteria stated in the Claims Administrator's medical policy on bariatric surgery. Please see the Bariatric Surgery medical policy at **www.premera.com/T-Mobile**.http://www.premera.com/T-Mobile- A summary of the criteria is shown below. The member must be diagnosed as one of the following:

- A Body Mass Index (BMI) greater than 40 kg/m2; or
- A BMI of 35 kg/m2 or more with at least one of the following conditions:
  - Established coronary heart disease, such as:
    - History of angina pectoris (stable or unstable)
    - History of angioplasty
    - History of coronary artery surgery
    - History of myocardial infarction
  - Other atherosclerotic disease, such as:
    - Abdominal aortic aneurysm
    - Hypertension that is uncontrolled or resistant to treatment (medically refractory) with a blood pressure (BP) greater than 140/90 despite optimal medical management (attempted medical management must have included at least 2 medications of different classes).
    - Peripheral arterial disease
    - Symptomatic carotid artery disease
  - Type 2 diabetes, uncontrolled by pharmacotherapy
  - Obstructive sleep apnea, as documented by a sleep study (polysomnography), that is uncontrolled by medical management (e.g., CPAP or oral appliance)
- And participation in a physician administered weight reduction program lasting at least three continuous months (over a 90-day period of time) within the 12-month period before surgery is considered.
  - Evidence of active participation documented in the medical record includes:
    - Weight
    - Current dietary program (e.g., MediFast, OptiFast)
    - Physical activity (e.g., exercise/work-out program)
- Or documentation of participation in a structured weight reduction program such as Weight Watchers or Jenny Craig is an acceptable alternative if done in conjunction with physician supervision

You must also have a mental health evaluation and clearance by a licensed mental health provider to rule out any mental health disorders that would be a contraindication to bariatric surgery, rule out inability to provide informed consent, and rule out inability to comply with pre- and post-surgical requirements.

For specific surgical treatment benefit information, please 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 (please see the ***Definitions*** section in this *Summary Plan Document*)
- Liposuction or surgical removal of excess skin unless medically necessary
- Over-the-counter medications for weight loss
- 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 18

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. 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.
- 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.*
- Medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the medical claims administrator makes a determination regarding coverage in a particular case are determined to be:
  - Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use;
  - Subject to review and approval by any institutional review board for the proposed use;
  - The subject of an ongoing clinical trial that does not meet the definition of a Covered Health Service under Clinical Trials; or
  - A service that does not meet the definition of a Covered Health Service.
- If a Covered Person has a "life-threatening" Sickness or condition (one which is likely to cause death within one year of the request for treatment) the medical claims administrator may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the Sickness or

condition. For this to take place, the medical claims administrator must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

- Liposuction.
- 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.
- Nutritional counseling unless medically prescribed. Non-disease specific, nutritional education such as general good eating habits, calorie control or dietary preferences (e.g., vegetarian, macro-biotic) is excluded from coverage.

  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.
- Services given by a pastoral counselor.
- 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
  - Required to obtain or maintain a license of any type.
- Private duty nursing services while confined in a facility.
- Psychosurgery (lobotomy).
- 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 mechanical or 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.
- Rest cures.
- Reversal of voluntary sterilization.
- 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 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 the American Psychiatric Association.
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
- 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.

- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Transitional Living services.
- Non-Medical 24-Hour Withdrawal Management.
- High intensity 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.
- 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;
- Bio-feedback and bioenergetic therapy;
- 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;
- Sensory or auditory integration therapy;
- Sleep therapy;
- 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
  - 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.
- 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, WHILE COVERED UNDER A HIGH DEDUCTIBLE HEALTH PLAN. 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 monthly 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 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 Annual Enrollment, you have the opportunity to review and change your benefit election. Any changes you make during Annual 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: 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.

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 be adjusted 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.

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. T-Mobile will remove $124.98 from the HRA plan, if the funds are still available, because the employee has no enrolled dependents as of October 1.

Reinstatement without a break in coverage. Following a termination, if you are rehired by T-Mobile USA, Inc., can you be reinstated without experiencing any break in coverage?

No—your HRA Plan does not allow reinstatement without experiencing any break in coverage. When you are rehired by T-Mobile USA, Inc. and re-enroll in the active medical plan and the HRA Plan the HRA Contribution amount will equal the amount a newly hired active employee would be eligible for. (See this Section under the heading *Mid-Year Enrollment*.)

Reinstatement with a break in coverage. Are you able to recover funds after a break in employment?

No—you cannot use prior accumulated balances after re-enrollment as a result of a break in employment. When you are rehired by T-Mobile USA, Inc. and re-enroll in the active medical plan and the HRA Plan the HRA Contribution amount will equal the amount a newly hired active employee would be eligible for. (See this Section under the heading *Mid-Year Enrollment*.)

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. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

COBRA continuation coverage must be offered with respect to a participant's HRA when the Plan is subject to COBRA. If your employment terminates for any reason the funds in your HRA will revert back to us 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 IRS 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—an expense that you incur specific to health care 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 co-payments; 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. Please 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. Please 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 327
Seattle, WA 98111-0327

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 nonprovision 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

NOTE: *You may also call customer service to verbally submit an external review request.*

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.

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)

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of their state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Chiropractor (DC)
- Dentist (DDS or DMD)
- Optometrist (OD)
- Podiatrist (DPM)
- Psychologist
- Nurse (RN and ARNP) licensed in Washington state

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.

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

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.

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 the ***How Providers Affect Your Costs*** section.

Inpatient

Confined in a medical facility as an overnight bed patient.

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 the ***How Providers Affect Your Costs*** section 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.

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 the ***How Providers Affect Your Costs*** section.

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 described in this Summary Plan Document.

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

Someone who is legally married to the subscriber. A spouse can also be the subscriber's domestic partner.

Subscriber

An enrolled employee of the Group. Coverage under this plan is established in the subscriber's name.

Subscription Charges

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.

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 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 (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 syringes with needles, blood testing strips—glucose, urine testing strips—glucose, ketone testing strips and tablets, lancets and lancet devices which are covered.);
- 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% co-insurance. 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% co-insurance 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.

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.

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 July 31, 2023. Contact your State for more information on eligibility.

ALABAMA — Medicaid	CALIFORNIA — Medicaid
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	**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
ALASKA — Medicaid	**COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	**Health First Colorado Website:** https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/ State Relay 711 **CHP+:** https://www.colorado.gov/pacific/hcpf/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
ARKANSAS — Medicaid	**FLORIDA — Medicaid**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268
GEORGIA — Medicaid	**MASSACHUSETTS — Medicaid and CHIP**
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	**Website:** https://www.mass.gov/masshealth/pa **Phone:** 1-800-862-4840 **TTY:** (617) 886-8102 Email: masspremassistance@accenture.com

INDIANA — Medicaid	MINNESOTA — Medicaid
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	**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
IOWA — Medicaid and CHIP (Hawki)	**MISSOURI — 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:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
KANSAS — Medicaid	**MONTANA — Medicaid**
Website: https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884 **HIPP Phone:** 1-800-967-4660	**Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084 **Email:** HHSHIPPProgram@mt.gov
KENTUCKY — Medicaid	**NEBRASKA — 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://kidshealth.ky.gov/Pages/index.aspx **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov	**Website:** http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178
LOUISIANA — Medicaid	**NEVADA — Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp **Phone:** 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	**Medicaid Website:** http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900

MAINE — Medicaid	NEW HAMPSHIRE — Medicaid
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.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	**SOUTH DAKOTA — 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:** http://dss.sd.gov **Phone:** 1-888-828-0059
NEW YORK — Medicaid	**TEXAS — Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831	**Website:** Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services **Phone:** 1-800-440-0493
NORTH CAROLINA — Medicaid	**UTAH — Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ **Phone:** 919-855-4100	**Medicaid Website:** https://medicaid.utah.gov/ **CHIP Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669
NORTH DAKOTA — Medicaid	**VERMONT — Medicaid**
Website: https://www.hhs.nd.gov/healthcareq **Phone:** 1-844-854-4825	**Website:** Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **Phone:** 1-800-250-8427
OKLAHOMA — Medicaid and CHIP	**VIRGINIA — Medicaid and CHIP**
Website: http://www.insureoklahoma.org **Phone:** 1-888-365-3742	**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
OREGON — Medicaid	**WASHINGTON — Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx **Phone:** 1-800-699-9075	**Website:** https://www.hca.wa.gov/ **Phone:** 1-800-562-3022

PENNSYLVANIA — Medicaid	WEST VIRGINIA — Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx **Phone:** 1-800-692-7462 **CHIP Website:** Children's Health Insurance Program (CHIP) (pa.gov) **CHIP Phone:** 1-800-986-KIDS (5437)	**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)
RHODE ISLAND — Medicaid and CHIP	**WISCONSIN — Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	**Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone:** 1-800-362-3002
SOUTH CAROLINA — Medicaid	**WYOMING — Medicaid**
Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820	**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 July 31, 2023, 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)

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.

Emotional Wellbeing Solutions (fka EAP)—LiveMagenta

Emotional Wellbeing Solutions through Optum is available to all Employees and their families regardless of whether you are enrolled with Premera Blue Cross (Premera) or UnitedHealthcare (UHC). Benefits begin on the first day of work or on the first day a dependent becomes eligible.

Confidential help available **1-855-780-5958** **or** **https://livemagenta.com**	■ Assessment and Counseling—Up to ten visits provided at no cost per concern per plan year for emotional wellbeing, addiction, relationship troubles and more. Call 24/7 and speak confidentially with a master's level specialist or get a referral for in-person or online virtual visits. Live chat is available during business hours. ■ Self-Care from the AbleTo App—Free on-demand support for stress, anxiety, and depression ■ Talkspace—Virtual therapy using secure text, audio, and video messages. ■ Financial Assistance—Unlimited access to work with credentialed money coaches on financial planning, debt management, investments, or other financial matters. ■ Mindfulness Sessions—Unlimited access to both live expert led and on-demand mindfulness sessions through eM Life. ■ Rally® Health—Personalized digital experience to help you reach your health goals. ■ Wellness Coaching—1:1 access online or telephonically with a wellness coach to help you get and stay healthy. ■ Quit for Life®—Quit tobacco program that includes coaching, text messaging, online learning and if you qualify Nicotine Replacement Therapy. ■ Legal Assistance—Legal services include one 30-minute initial consultation per personal legal matter with an attorney, plus get a 25% discount for ongoing services. Legal services address issues like landlord/tenant disputes, personal injury, or bankruptcy. ■ Family Mediation—Access to information and/or referral to a mediator to resolve family disputes in lieu of pursuing litigation. ■ Child and Parenting Support Services—Extensive services for families and children up to age 18, including information and consultation on all kinds of parenting questions, resources for daycare, summer camps, adoption, sick-child care, and more. ■ Adult and Elder Support Services—Resources for people caring for adult and elder dependents, including caregiving and housing options, chronic illness support, transportation and meal services and senior activity groups. ■ Chronic Condition Support—Valuable information and support services for employees and dependents who have a chronic illness like diabetes, heart disease, arthritis, or asthma. ■ Life Learning—Educational resources for all ages and abilities, including help with locating and evaluating schools, finding classes for special needs children, and arranging tutoring services.

	■ Convenience Services—Verified resources for a variety of situations including pet sitting, home improvement and repair, recreational activities and entertainment and dining. ■ **https://livemagenta.com**—A robust website with information and resources on a wide range of health and wellness topics. ■ Life Stages Help Centers—Providing information and resources on parenting, eldercare, anxiety and coping with chronic conditions. ■ On-Line Articles and Resources—Information available on health, wellness, and personal development. Learn to cope with stress, manage major life changes or balance work and life issues. ■ Personal Plans and Self-Assessment Tests—Use tools that will help you build communication skills, improve health and fitness, or quit smoking.

Nurse Line

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, 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 (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 (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 (800) 211-0359 or (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 (360) 725-7263 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 convert your coverage to an individual policy. You must apply within 31 days after termination of your group coverage. The benefits and Premium costs may be different from those available under your current plan. There may be a gap in coverage between the dates your coverage under your current Plan ends and the date that coverage begins under an individual policy.

You may apply for coverage under a DDWA individual Plan online at **www.DeltaDentalWA.com/Individual** or by calling (800) 286-1885 to have an application sent to you. Converted policies are subject to certain benefits and limits.

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, providing the employee is enrolled and the dependent is in compliance with the age limitation.

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.
  - 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 under this plan are subject to limitations listed above which affect the benefits you receive or how often some procedures will be covered. 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 (206) 522-2300 or call toll-free at (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

An oral or written communication by a subscriber requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate 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 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 you 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 co-payments 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 $15 copay	Reimbursed up to $45 after $15 copay
Lenses	Single vision	One pair every plan year One $25 copay applies to both lenses and frames. 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

* *Coverage with a retail chain affiliate may be different. Once your benefit is effective; visit vsp.com for details. Discounts are not available at Costco/Walmart Sam's Club, Costco/Walmart Sam's Club pricing applies.*

Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

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 http://www.vsp.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.

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;
- 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 (vsp.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 495918
Cincinnati, OH 45249-5918

Claims can also be submitted on-line on our member portal on vsp.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

(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) Plans	
Health Care Spending Account	
Contributions	■ Maximum of $3,200 as pretax contribution per plan year. ■ If you have unused Health Care Spending Account dollars at the end of the plan year, up to $640 will carry over to the next year. Amounts above $640 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 co-pays, co-insurance, 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 $5,000 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.

Section 125 Flexible Spending Account (FSA) Plans

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, annual 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 Your Spending 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 months 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 Your Spending 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, Your Spending Account will notify you within 30 days of receipt of such claim. Should Your Spending Account face delays not of its own creation, Your Spending 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 Your Spending 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 Your Spending 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:

Your Spending Account
P.O. Box 64030
The Woodlands, TX 77387-4030

Appeals are reviewed by Your Spending 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 Your Spending 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 $3,200 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. 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 Your Spending Account Customer Service desk 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 Health Care Card. If you choose to activate it, you can use the card to pay for eligible health care products and services directly from your Health Care Spending Account. 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 Health Care card, your claims for reimbursement will be made on forms provided by Your Spending Account.

Your Spending Account's Online Claim Wizard will guide you in submitting claims online, providing instant feedback on the eligibility of the expense being submitted. Access your account at www.t-mobilebenefits.com, go to the Online Dashboard, click on the Online Claim Wizard, complete the online form, and use the automated fax cover sheet or online upload to submit documentation. Claims should be faxed to Your Spending Account at 1-888-211-9900. If you choose to mail your claim, send your original signed claim form along with legible copies of your supporting documentation to Your Spending Account, P.O. Box 64030, The Woodlands, TX 77387-4030. Claims will be reimbursed on a predetermined schedule. The Plan Administrator will notify you of this schedule.

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 $610 will carry over to the next Plan Year. Amounts above $610 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 $610 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 YSA™ card or out-of-pocket and submit qualified expenses for reimbursement using the HCSA Claim Form. You can submit a claim online on the YSA website or you can submit a paper claim to YSA using the HCSA Claim Form. The claim-filing instructions are on the YSA website and the HCSA Claim Form.

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 $5,000 ($2,500 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 Your Spending Account Customer Service desk 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 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 $5,000 per Plan Year*[11].

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.

[11] *The IRS limit is $5,000 per calendar year. This is an IRS Regulation and not a rule that T-Mobile can change.*

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.

Reimbursement Procedures

Claims for reimbursement can be made through the Your Spending Account website, which can be accessed through **www.t-mobilebenefits.com** or by calling Your Spending Account at 1-855-TMO-BENS (855-866-2367). Claims for reimbursement can also be made using the Reimburse Me! application on your mobile device. Completed claim forms and receipts can be uploaded directly onto the Your Spending Account website or by using the Reimburse Me! application on your mobile device. In addition, you may fax the completed forms and receipts to Your Spending Account at 1-888-211-9900. If you choose to mail your claim, send your original signed claim form along with the legible copies of your supporting documentation to Your Spending Account, P.O. Box 64030, The Woodlands, TX 77387-4030. Claims are reimbursed on a daily basis.

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.

Short Term Disability / Maternity Benefits Summary

This benefits guide contains important information regarding your short-term disability benefits, including maternity benefits (the "Program"). These benefits provide eligible employees with short-term income protection in the event of a Disability due to a covered Injury, Sickness, Mental Illness, Substance Abuse, or pregnancy. These benefits are provided through the T-Mobile USA, Inc. Employee Benefits Plan (the "Plan"). This document, along with the policies and procedures utilized with respect to any adverse benefit determination, shall constitute the plan document and the summary plan description for the Program as required by ERISA. The benefits described herein are those in effect as of January 1, 2022.

ELIGIBILITY

Eligible Employees:

All Full-time Active Employees and Part-time Active Employees, excluding interns, temporary, leased, or seasonal employees.

- Full-time Employment: at least 30 hours weekly.
- Part-time Employment: less than 30 hours weekly.

Eligibility Waiting Period for Coverage:

The first day of the month following completion of 180 days of employment. Exception: if the 180th day of employment falls on the first day of a month you are eligible on that day.

The time period referenced above is continuous and does not include periods of employment prior to your most recent hire date.

EXAMPLES:

You meet your 180 days of employment on August 2nd. Your coverage will become effective on September 1st if you were Actively at Work on your last scheduled day before September 1st. If not, your effective date for coverage will be deferred.

You meet your 180 days of employment on August 1st. Your coverage will become effective on August 1st if you were Actively at Work on your last scheduled day before August 1st. If not, your effective date for coverage will be deferred.

PERIOD OF COVERAGE

Effective Date:

When does my coverage start?

Your coverage will start on the date you become eligible.

Deferred Effective Date:

When will my effective date for coverage or a change in my coverage be deferred?

If you are absent from work due to:

- Accidental bodily injury;
- Sickness;

- Mental Illness;
- Substance Abuse; or
- Pregnancy;

on the day prior to the date your coverage would otherwise have become effective, your insurance will not become effective until you are Actively at Work one full day.

Exception: If after being Actively at Work you are absent again for the related or same cause within 30 calendar days, your insurance will not become effective. See Recurrent Disability.

EXAMPLES:

Due to same cause: You go out on a continuous absence on August 5th, but you are not eligible for STD until September 1st, therefore you are denied STD benefits. If you return to work after September 1st but do not remain at work for 30 consecutive days or more and go back out on absence due to the same or related condition then your STD will remain denied because you were not eligible for STD when you went out on the continuous absence.

Due to new condition that is unrelated: You go out on a continuous absence on August 5th, but you are not eligible for STD until September 1st, therefore you are denied STD benefits. If you return to work after September 1st and go back out of work due to a new disabling condition, you would be eligible for STD.

Termination:

When will my coverage end?

Your coverage will end on the earliest of the following:

- The date the Program terminates;
- The date you are no longer an Eligible Employee; or
- The date you cease to be an Active Employee in an eligible class for any reason; unless continued in accordance with one of the Continuation Provisions.

Continuation Provisions:

Can my coverage be continued beyond the date it would otherwise terminate?

Coverage can be continued by your Employer beyond a date shown in the Termination provision, if your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

- Is subject to any reductions in the Program; and
- Terminates if:
  - The Program terminates; or
  - Coverage for your class terminates.

In any event, your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before your coverage was continued. The Continuation Provisions shown below may not be applied consecutively. The maximum amount of time covered under the continuation provision from the start of your continuous leave would be 12 months. Coverage may be continued in accordance with the above restrictions and as described below:

- **Military Leave of Absence:** If you enter active military service and are granted a military leave of absence in writing, your coverage may be continued for up to 12 months. If your military leave ends prior to the agreed upon date, this continuation will cease immediately.
- **Family Medical Leave:** If you are granted a leave of absence in writing, under the Family and Medical Leave Act of 1993, or other applicable state or local law, your coverage may be continued for up to 12 weeks, or 26 weeks if you qualify for Family Military Leave, or longer if required by other applicable law, following the date your leave commenced. If this leave terminates prior to the agreed upon date, this continuation will cease immediately.

- **Leave of Absence:** If you are on an approved leave of absence, other than Family and Medical Leave or Military Leave of Absence, your coverage may be continued for up to 12 months following the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage While Disabled:

Does my coverage continue while I am Disabled and no longer an Active Employee?

If you are Disabled and you cease to be an Active Employee, your coverage will be continued:

- While you remain Disabled; and
- Until the end of the period for which you are entitled to receive short term Disability Benefits.

After short term Disability benefit payments have ceased, your coverage will be reinstated, provided:

- You return to work for one full day as an Active Employee in an eligible class; and
- The Program remains in force.

BENEFITS

Date Benefits Commence:

- For Disability caused by Injury or Sickness—the 8th consecutive full calendar day of absence after the date of Disability; or
- For Disability caused by Delivery—the date of Delivery (see Maternity Leave Benefit).

Weekly Benefit:

Week 1 is an Elimination Period, no Benefit is paid.

Week 2 – 26: 75% of your Pre-Disability Earnings, reduced by Deductible Income.

See *Maternity Leave Benefit* for enhanced Weekly Benefit available if you are absent from work due to Delivery (*Benefits* section).

Pre-Disability Earnings:

Pre-Disability Earnings are comprised of up to two components. Both are based on your pay as of the last day you actively worked before you became Disabled.

- **Annual Target Base Pay:**
  - This is your Total Base Pay listed in Workday.
  - Annual Target Base Pay also includes contributions you make through a salary reduction agreement with your Employer to an Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement or an executive nonqualified deferred compensation arrangement; and amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.
- **Annual Target Sales Incentive Pay:**
  - This component only applies to incentive-eligible employees with a career band designated as SL, Customer and Frontline Experience Roles in T-Mobile for Business, and Customer Experience Center employees with a monthly incentive plan (i.e., not an annual corporate bonus plan)
  - This is your target annual incentive listed in Workday. If you are part-time, your annual incentive listed in Workday will be prorated based on your FTE percent in Workday.

Pre-Disability Earnings does not include anything other than the amounts listed above. So, it doesn't include corporate bonus, tips, tokens, overtime/double-time pay, shift differential pay, stock options, prizes, gifts, stock bonuses, any other fringe benefits, your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other compensation.

Weekly Rate of Pay:

Your Weekly Rate of Pay means your Pre-disability Earnings divided by 52.

Maximum Duration of Benefits:

The maximum duration of disability benefits is 26 weeks reduced by your Elimination Period if caused by Injury, Sickness, Mental Illness, Substance Abuse, or Pregnancy (prior to Delivery).

Example—You have surgery on August 1 and are expected to be disabled for 26 weeks. Week 1, August 1 – 7 is unpaid, weeks 2 – 26 are eligible for pay (if Disabled).

See Maternity Leave Benefit in the Benefits section for enhanced Weekly Benefit available if you are absent from work due to Delivery.

Disability Benefit:

When am I eligible to receive disability benefits under the Program? If, while eligible for this Benefit, you:

- Become Totally Disabled;
- Remain Totally Disabled; and
- Submit Proof of Loss to the Claims Administrator;

What are my disability benefits under the Program?

If you satisfy the eligibility requirements, the Program will pay the Weekly Benefit.

The amount of any Weekly Benefit payable will be reduced by:

- The total amount of all Deductible Income, including any amount for which you could collect but did not apply.

Partial Week Payment:

How is a benefit calculated for a period of less than a week?

If a Weekly Benefit is payable for less than a week, the Program will pay 1/5 of the Weekly Benefit for each day you were Disabled.

Recurrent Disability:

What happens to my benefits if I return to work as an Active Employee and then become Disabled again?

When you return to work as an Active Employee or remain off work for a reason **not** related to your Disability such as for Bonding, Care of Family Member or other paid or unpaid leave, a period of approved PTO or unpaid time off and then remain off work related to a Disability, and such Disability is:

- Due to the same cause (Injury, Sickness, Mental Illness Substance Abuse, or pregnancy) or
- Due to a related cause; and
- Within 30 consecutive calendar days of the return to work.

If you were eligible, and approved for benefits, the Period of Disability prior to your return to work and the recurrent Disability will be considered one Period of Disability, provided the Program remains in force.

If you return to work as an Active Employee or remain off work for the reasons noted above for 30 consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

EXAMPLES:

- You are out from July 1 to July 28 and are approved for STD. (July 1 – 7) is your Elimination Period, no benefit paid. The 3 weeks from July 9 to July 28 are paid at 75%. You return to work on July 29 and then from August 20 to January 20 you go back out due to the same condition. If the new period of continuous absence is approved for STD, you would not need to complete another Elimination Period and the 22 additional weeks of absence would count as week's 5 – 26 of your STD Benefit.

If in the above example, you go back out due to a new condition that is unrelated, this would be considered a new claim and you would be eligible for 26 weeks of STD benefits reduced by a (1) week Elimination Period.

- You are out from July 1 to July 28 and are approved for STD. (July 1 – 7) is your Elimination Period, no benefit paid. The 3 weeks from July 8 to July 28 are paid at 75%. You transition to a continuous leave of absence to care for an ill family member from July 29 to August 20 and then remain on a continuous leave for the same condition as the July 1 STD claim. If the new period of continuous absence is approved for STD, you would not need to complete another Elimination Period and the 22 additional weeks of absence would count as weeks 5 – 26 of your STD Benefit.

If in the preceding example, you remain out due to a new condition that is unrelated, this would be considered a new claim and you would be eligible for 26 weeks of STD benefits reduced by a (1) week Elimination Period.

Period of Disability:

A continuous length of time during which you are Disabled under the Program.

Multiple Causes:

How long will benefits be paid if a period of Disability is extended by another cause?

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while you remain Disabled, subject to the following:

- Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
- Any Exclusions will apply to the new cause of Disability.

Termination of Payment:

When will my benefit payments end?

Benefit payments will stop on the earliest of:

- The date you are no longer Disabled;
- The date you fail to furnish Proof of Loss;
- The date you are no longer under the Regular Care of a Physician;
- The date you refuse the Claims Administrator's request that you submit to an examination by a Physician or other qualified medical professional;
- The date of your death;
- The date you refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct, or limit the disabling condition;
- The date you engage in leisure travel. Travel required for medical treatment is acceptable, such as traveling to a specialty clinic for a medical appointment or procedure;
- The date you engage in activities or conduct which is inconsistent with the medical condition;

- The date that you engage in similar outside employment activities (except required military duties), except where applicable law permits otherwise;
- The first date benefits were payable based on your submission of fraudulent paperwork;
- The last day benefits are payable according to the Maximum Duration of Benefits;
- The date your Current Weekly Earnings exceed 80% of your Pre-disability Earnings; or
- The date no further benefits are payable under any provision in the Program that limits benefit duration.

Disabled and Working Benefits:

How are benefits paid when I am Disabled and Working?

If, while covered under this benefit, you are Disabled and Working, the Claims Administrator will use the following calculation to determine your Weekly Benefit:

Weekly Benefit = (A – B) x C

Where:

A = Your Weekly Pre-disability Earnings.

B = Your Current Weekly Earnings.

C = The Weekly Benefit percentage payable if you were Totally Disabled.

Maternity Leave Benefit:

How are benefits paid if I am absent from work due to Delivery?

Starting with the date of your Delivery, for a period of up to eight (8) weeks, your Weekly Benefit will be 100% of your Weekly Rate of Pay. The seven (7) day Elimination Period will be waived starting on the date of your Delivery. If you remain Disabled after the eight-week Maternity Leave Benefit, your Weekly Benefit as defined by the Program will resume. The Maternity Leave Benefit does not increase the overall Maximum Duration of Benefits Payable under the Program unless you are Disabled prior to Delivery. In that case, the Maternity Leave Benefit will be paid for the full eight weeks even if the total claim duration of Benefits exceeds 26 weeks.

When should the Claims Administrator be notified of a Maternity Leave claim?

You, your supervisor, or your Physician must give the Claims Administrator notice of a claim by calling the special claims telephone number provided to Employees. Such notice must be given no later than the seventh calendar day of an absence due to the same or a related Disability.

When must Maternity Leave claim information be given?

Written claim information must be sent to the Claims Administrator within 15 calendar day(s) after the start of the period for which the Claims Administrator is liable for payment. If claim information is not given by the time it is due, it will not affect the claim if:

- It was not possible to provide claim information within the required time; and
- Claim information is given as soon as possible.

What is required to properly file a Maternity Leave claim?

An Eligible Employee will be required to furnish appropriate medical documentation for the Delivery of a child. The medical documentation will be completed and signed by the individual’s health care provider.

EXCLUSIONS AND LIMITATIONS

Exclusions:

What Disabilities are not covered?

The Program does not cover and will not pay a benefit for any Disability:

- Unless you are under the Regular Care of a Physician;
- That is caused or contributed to by war or act of war (declared or not);
- Caused by your commission of or attempt to commit a felony;
- Caused or contributed to by your being engaged in an illegal occupation;
- Caused or contributed to by an intentionally self-inflicted Injury;
- For which Workers' Compensation benefits are paid, or may be paid, if duly claimed;
- Sustained as a result of doing any work for pay or profit for another employer;
- That is for elective cosmetic procedures; or
- That are related to falsified information submitted regarding your disability.

GENERAL PROVISIONS

Claims Administrator:

What is the role of the Claims Administrator?

The Claims Administrator:

- Determines benefits payable according to the terms and conditions of the Program

However, the Employer has the responsibility for deciding final appeals of claims which were initially denied by the Claims Administrator, and for making final determinations regarding eligibility for coverage.

Notice of Claim:

When should the Claims Administrator be notified of a claim?

You, your supervisor, or your Physician must give the Claims Administrator notice of a claim by calling the special claims telephone number provided to Employees. Such notice must be given no later than the seventh calendar day of an absence due to the same or a related Disability.

Claim Forms:

Are special forms required to file a claim?

The Claims Administrator will send forms to you to file a claim, within 15 days of receiving a notice of claim. If the Claims Administrator does not send the forms within 15 days, you may submit any other proof which fully describes the nature and extent of your claim.

Filing a Claim:

What is required to properly file a claim?

Filing a claim may include but is not limited to the following:

- Documentation of:

- The date your Disability began;
- The cause of your Disability;
- The prognosis of your Disability;
- Your Pre-disability Earnings, Current Weekly Earnings, or any income, including but not limited to copies of your filed and signed federal and state tax returns; and
- Evidence that you are under the Regular Care of a Physician.

- Any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental, or diagnostic examinations and treatment notes;
- The names and addresses of all:
  - Physicians or other qualified medical professionals you have consulted;
  - Hospitals or other medical facilities in which you have been treated; and
  - Pharmacies which have filled your prescriptions within the past three years.
- Your signed authorization for the Claims Administrator to obtain and release:
  - Medical, employment and financial information; and
  - Any other information the Claims Administrator may reasonably require.
- Your signed statement identifying all Deductible Income; and
- Proof that you and your dependents have applied for all Deductible Income that is available.

All information submitted must be satisfactory to the Claims Administrator.

Additional Information:

What additional information is the Claims Administrator entitled to?

To assist the Claims Administrator in determining if you are Disabled, or to determine if you meet any other term or condition of the Program, the Claims Administrator has the right to require you to:

- Meet and interview with the Claims Administrator; and
- Be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of the Claims Administrator's choice.

Any such interview, meeting or examination will be:

- At the Claims Administrator's expense; and
- As reasonably required by the Claims Administrator.

The additional information must be satisfactory to the Claims Administrator. Unless the Claims Administrator determines you have a valid reason for refusal, the Claims Administrator may deny, suspend, or terminate your benefits if you refuse to be examined or meet to be interviewed by the Claims Administrator.

Sending Claim Information:

When must claim information be given?

Written claim information must be sent to the Claims Administrator within 15 day(s) after the start of the period for which the Claims Administrator is liable for payment. If claim information is not given by the time it is due, it will not affect the claim if:

- It was not possible to provide claim information within the required time; and
- Claim information is given as soon as possible.

The Claims Administrator may request claim information and documentation throughout your Disability. In such cases, the Claims Administrator must receive the requested information and documentation within 15 calendar days of the request.

Claim Payment:

When are benefit payments issued?

When the Claims Administrator determines that you:

- Are Disabled; and
- Eligible to receive benefits.

The Claims Administrator will submit the amount of benefit to be paid on a weekly basis to T-Mobile for processing on a weekly pay schedule. You will receive the funds in the same manner that you receive your regular pay. If any payment is due after a claim is terminated, it will be paid as soon as claim information satisfactory to the Claims Administrator is received.

When does an overpayment occur?

An overpayment occurs:

- When we determine that the total amount that has been paid in benefits is more than the amount that was due to you under the policy; or
- When payment is made that should have been made under another group policy or statutory plan.

This includes, but is not limited to, overpayments resulting from:

- Retroactive awards received from sources listed in the other income benefits definition;
- Failure to report, or late notifications to us of any other income benefit(s) or earned income;
- Misstatement (i.e., incorrect date of disability)
- Fraud; or
- Any errors we make.

What Happens If the Claim Administrator Overpays Your Claim?

The Claim Administrator has the right to recover any overpayments. You must reimburse the overpayment in full. The Claim Administrator will determine the method by which the repayment is to be made. The Claim Administrator will not recover more money than the amount we paid you.

CLAIMS PROCEDURES

The Employer has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan.

Claim and Appeal Procedures for Claims Requiring a Determination of Disability.

Claims for Benefits:

The claim decision will be made no more than 45 days after receipt of your properly filed claim. 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 Claim 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 you and vocational professionals who evaluated you, 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 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 for benefits.

Appealing Denial of Claims for Benefits:

First Level Appeal

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

As part of your first level 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 Claims Administrator's review of your first level 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.

A first level appeal decision will be made no more than 45 days after the Claims 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 Claims 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 Claims Administrator receives your response to the request.

The individual reviewing your first level appeal shall give no deference to the initial benefit 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 a first level appeal that is based in whole or part on medical judgment, the Claims 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 benefit decision, nor a subordinate of such individual.

The Claims 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 first level appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your first level appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your first level appeal is based on a new or additional rationale, the Claims 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 first level appeal, so that you will have a reasonable opportunity to respond prior to that date.

If the Claims Administrator grants your first level 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 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 you and vocational professionals who evaluated you, 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 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 Claims Administrator will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

Second Level Appeal

If you are not satisfied with the determination of the Claims Administrator on your first level appeal, you can submit a second level appeal to the Claims Administrator. All second level appeals should be submitted in writing to the Claims Administrator within 180 days after you receive the notice of determination on your first level appeal.

Like first level appeals, the review of a second level appeal will afford no deference to prior determinations and will be conducted by someone other than the individuals who made the prior determinations or subordinates of such individuals. Also, if the first level appeal was denied based on a medical judgment, the Claims Administrator may consult with a health

professional with appropriate training and experience in the pertinent field of medicine, and who is not a professional consulted during the prior determinations, or a subordinate of such professional. The Claims Administrator will also identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination being appealed, even if the advice was not relied upon in making the benefit determination.

The Claims 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 second level appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your second level appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your second level appeal is based on a new or additional rationale, the Claims 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 second level appeal, so that you will have a reasonable opportunity to respond prior to that date.

The Claims Administrator, in consultation with the Plan Administrator, will review and decide your second level appeal. The Claims Administrator will provide you written or electronic notification of the determination on your second level appeal not later than 45 days after the Claims Administrator receives your timely request for a second level 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 Claims Administrator expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your second level 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 Claims Administrator receives your response to the request.

Denial notifications of second level appeals will include the information listed above for first level appeal denials.

You are required to utilize both the first and second levels of appeal as provided under the Plan in order to be considered to have exhausted your claim and appeal rights under the Plan, which is required before filing a lawsuit to dispute your claim, as further described in the last paragraph of this "Claims Procedures" section.

Claim and Appeal Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

The claim decision will be made no more than 90 days after receipt of your properly filed claim. However, if there are special circumstances that require an extension, the time for claim decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, you are notified in writing of the special circumstances and are given the date by which a decision is expected to be made. If extended, a decision shall be made no more than 180 days after your claim was received. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Plan provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the Claims Administrator for a full and fair review. Your appeal request must be in writing and be received by the Claims Administrator no later than the expiration of 60 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 review on appeal 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.

A final decision will be made no more than 60 days after it receives your timely appeal. However, if special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, you are notified in writing of the special circumstances and given the date by which the Claims Administrator expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Claims Administrator grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Plan provisions on which the decision is based, 2) 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 the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

No person may bring a legal action for benefits unless and until he or she has timely made a benefits claim and appealed a denied claim within the time limits and procedures described in this section. Further, no action may be brought against the Plan or T-Mobile or any of their delegates, employees, officers, or Board members more than one year after the earlier of the decision became final, the claimant has exhausted their claim and appeal rights under the Plan, or the date proof of claim was due.

DEFINITIONS

Actively at Work means at work with your Employer on a day that is one of your Employer's scheduled workdays. On that day, you must be performing for wage or profit all of the regular duties of your Occupation:

- In the usual way; and
- For your usual number of hours.

You will be considered Actively at Work on a day that is not a scheduled work day only if you were Actively at Work on the preceding scheduled work day.

Active Employee means an employee who works for T-Mobile on a regular basis in the usual course of T-Mobile's business either Full-time or Part-time, excluding interns, temporary, leased, or seasonal employees.

Claims Administrator means Broadspire Services, Inc.

Current Weekly Earnings means Weekly earnings you receive from your Employer while you are Disabled and eligible for the Disabled and Working Benefit.

Current Weekly Earnings also includes the pay you could have received for another job or a modified job if:

- Such job was offered to you by your Employer and you refused the offer; and
- The requirements of the position were consistent with:
  - Your education, training, and experience; and
  - Your capabilities as medically substantiated by your Physician.

Deductible Income:

- Any amount you receive or are eligible to receive or should have filed for because of your disability under a state disability income benefit law or similar law;
- Any amount you receive or are eligible to receive because of your disability under another group coverage;
- Any disability or retirement benefits you receive under your Employer's retirement plan;

- Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law;
- Any amount you receive or are eligible to receive from or on behalf of a third party because of your disability, whether by judgment, settlement, or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as Deductible Income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees; and
- Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

Deductible Income does not include:

- Any cost-of-living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income;
- Reimbursement for hospital, medical, or surgical expense;
- Reasonable attorneys' fees incurred in connection with a claim for Deductible Income;
- Benefits from any individual disability insurance policy;
- Group credit or mortgage disability insurance benefits;
- Accelerated death benefits paid under a life coverage plan or life insurance policy;
- Benefits from the following:
  - Profit sharing plan;
  - Thrift or savings plan;
  - Deferred compensation plan;
  - Plan under IRC Section 401(k), 408(k), 408(p), or 457;
  - Individual Retirement Account (IRA);
  - Tax Sheltered Annuity (TSA) under IRC Section 403(b);
  - Stock ownership plan; and
  - Keogh (HR-10) plan.
- The following amounts under your Employer's retirement plan:
  - A lump sum distribution of your entire interest in the plan;
  - Any amount which is attributable to your contributions to the plan; and
  - Any amount you could have received upon termination of employment without being disabled or retired.
- Benefits from the following:
  - Military pension and disability income plans;
  - Franchise disability income plans; and
  - A retirement plan from another employer.

Delivery means live birth of child by Vaginal or C-section delivery. This would not include a miscarriage or a stillborn delivery as these are not considered the live birth of a child.

Disabled and Working means that you are prevented by:

- Injury;
- Sickness;
- Mental Illness;

- Substance Abuse; or
- Pregnancy;

from performing some, but not all of the Essential Duties of your Occupation, are working on a part-time or limited duty basis, and as a result, your Current Weekly Earnings are more than 20%, but are less than or equal to 80% of your Pre-disability Earnings.

Disability or Disabled means Total Disability

Elimination Period means a 7-consecutive full calendar day period at the beginning of any one period of Disability which must elapse before benefits are payable.

Employer means T-Mobile USA, Inc.

Essential Duty means a duty that:

- Is substantial, not incidental;
- Is fundamental or inherent to the occupation; and
- Cannot be reasonably omitted or changed.

Your ability to work the number of hours in your regularly scheduled workweek is an Essential Duty.

During the COVID-19 pandemic, when you are required to work on-site, being COVID-19 free and wearing a mask (in locations where this is required) are considered "Essential Duties."

Injury means bodily injury resulting:

- Directly from accident; and
- Independently of all other causes;

which occurs while you are covered under the Program. However, an Injury will be considered a Sickness if your Disability begins more than 30 days after the date of the accident.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of the Program, Mental Illness does not include the following mental disorders outlined in the current version of the Diagnostic and Statistical Manual of Mental Disorders:

- Mental Retardation;
- Pervasive Developmental Disorders;
- Motor Skills Disorder;
- Substance-Related Disorders;
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
- Narcolepsy and Sleep Disorders related to a General Medical Condition.

Occupation means your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job you are performing for T-Mobile or at a specific location.

Physician means a person who is:

- A Doctor of Medicine, osteopathy, psychology, or other legally qualified practitioner of a healing art that the Claims Administrator recognize or are required by law to recognize;
- Licensed to practice in the jurisdiction where care is being given;
- Practicing within the scope of that license; and
- Not Related to you by blood or marriage.

Pre-Disability Earnings are comprised of up to two components. Both are based on your pay as of the last day you actively worked before you became Disabled.

- **Annual Target Base Pay:**
  - This is your Total Base Pay listed in Workday.
  - Annual Target Base Pay also includes contributions you make through a salary reduction agreement with your Employer to an Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement or an executive nonqualified deferred compensation arrangement; and amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.
- **Annual Target Sales Incentive Pay:**
  - This component only applies to incentive-eligible employees with a career band designated as SL, Customer and Frontline Experience Roles in T-Mobile for Business, and Customer Experience Center employees with a monthly incentive plan (i.e., not an annual corporate bonus plan).
  - This is your target annual incentive listed in Workday. If you are part-time, your annual incentive listed in Workday will be prorated based on your FTE percent in Workday.

Pre-Disability Earnings does not include anything other than the amounts listed above. So, it doesn't include corporate bonus, tips, tokens, overtime/double-time pay, shift differential pay, stock options, prizes, gifts, stock bonuses, any other fringe benefits, your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other compensation.

Program means short-term disability benefits, including maternity benefits

Regular Care of a Physician means that you are being treated by a Physician:

- Whose medical training and clinical experience are suitable to treat your disabling condition; and
- Whose treatment is:
  - Consistent with the diagnosis of the disabling condition;
  - According to guidelines established by medical, research, and rehabilitative organizations; and
  - Administered as often as needed; to achieve the maximum medical improvement.

Related means your spouse or other adult living with you, sibling, parent, stepparent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Sickness means a Disability which is:

- Caused or contributed to by:
  - Any condition, illness, disease, or disorder of the body;
  - Any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
  - Hernia of any type unless it is the immediate result of an accidental Injury covered by the Program; or
  - Pregnancy.
- Caused or contributed to by any medical or surgical treatment for a condition shown in items above.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

- Impairments in social and/or occupational functioning;
- Debilitating physical condition;
- Inability to abstain from or reduce consumption of the substance; or

- The need for daily substance use to maintain adequate functioning. Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means:

- You are considered disabled if you are limited from performing one or more of the Essential Duties (Main Responsibilities) of your occupation solely due to your Sickness, Injury, Mental Illness, Substance Abuse, or pregnancy that causes you to be absent from work for at least 8 consecutive full calendar days in a row.

Weekly Rate of Pay means your Pre-disability Earnings divided by 52.

PROGRAM ADMINISTRATIVE FACTS

Plan Name:

The Short-Term Disability and Maternity Leave Program provided under the T-MOBILE USA, INC. EMPLOYEE BENEFIT PLAN.

Plan Number

506

Employer/Plan Sponsor

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

Employer Identification Number

91-1983600

Type of Plan

Welfare Benefit Plan providing Group Short Term Disability and Maternity Leave benefits.

Plan Administrator

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

Agent for Service of Legal Process

For the Plan:

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

For the Claims Administrator:

Broadspire Services, Inc.
PO BOX 14773
Lexington KY 40512

Sources of Contributions:

The cost of the Program benefits are paid entirely by the employer.

Type of Administration:

The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan Document.

The Plan and its records are kept on a Plan year basis.

Plan Amendment Procedure:

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend, or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

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:

(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

OptumRx

PO Box 29077
Hot Spring, AZ 71903

Premera Blue Cross

7001 220th St. S.W.
Mountlake Terrace, WA 98111

Phone: 1-866-358-2300

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) and Premera Blue Cross (Premera).

Premera Blue Cross (Premera) 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 or UHC medical plan offering, as appropriate. In exercising their fiduciary responsibility, Premera 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.

Dental Claims Administrator:

Delta Dental of Washington

P.O. Box 75688
Seattle, WA 98125-0688

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

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:

Your Spending Account

P.O. Box 64030
The Woodlands, TX 77387-4030

1-855-TMO-BENS

Type of Administration:

The Plan is administered on behalf of the Plan Administrator by Your Spending Account.

Short Term Disability Claims Administrator:

Broadspire Services, Inc.
PO BOX 14773
Lexington KY 40512

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 (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.

Group Disability Income Insurance

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

CERTIFICATE OF INSURANCE

Policyholder: T-MOBILE USA, INC.
Policy Number: GLT-402610
Policy Effective Date: June 1, 2013
Policy Anniversary Date: January 1, 2023

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Kevin Barnett, Secretary **Jonathan Bennett, President**

A note on capitalization in this certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

Form GBD-1200 (10/08) (Rev-1) (WA) (402610) 2.55

SCHEDULE OF INSURANCE

The Policy of Long-Term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, sickness, or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

The benefits described herein are those in effect as of January 1, 2022.

2023 Cost of Coverage:

Options 1, 2 & 3— Depending upon the coverage for which You are enrolled, You must contribute toward the cost of coverage under Options 1, 2 & 3.

Disclosure of Fees:

We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:

In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Disclosure of Payment to the Policyholder:

We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:

1) Audit;

2) Marketing communication services; and

Other administrative expenses.

Eligible Class(es) For Coverage:

All Full-time and Part-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding Puerto Rico employees and excluding temporary, leased, or seasonal employees as follows:

Class 1: All Full-time Active Employees
Class 2: All Part-time Active Employees
Class 3: All Full-time Active Employees who are customer experience center employees
Class 4: All Part-time Active Employees who are customer experience center employees

Full-time Employment: at least 30 scheduled hours weekly

Part-time Employment: at least 20 scheduled hours weekly

Annual Enrollment Period:

As determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:

The first day of the month coinciding with or next following 180 day(s) of employment.

The time period(s) referenced above are continuous. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer under the Prior Policy.

Elimination Period:

Option 1: 180 day(s)
Option 2: 180 day(s)
Option 3: 180 day(s)

Maximum Monthly Benefit:

Option 1: $20,000
Option 2: $20,000
Option 3: $20,000

Minimum Monthly Benefit:

Option 1: $100
Option 2: $100
Option 3: $100

Benefit Percentage:

Option 1: 50%
Option 2: 60%
Option 3: 66.67%

Maximum Duration of Benefits:

Option 1:

Maximum Duration of Benefits Table

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

Option 2 & 3:

Maximum Duration of Benefits Table

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

Additional Benefit:

Family Care Credit Benefit
see benefit

Survivor Income Benefit
see benefit

Workplace Modification Benefit
see benefit

Ability Plus Benefit
see benefit

ELIGIBILITY AND ENROLLMENT

Eligible Persons:

Who is eligible for coverage?

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage:

When will I become eligible?

You will become eligible for coverage on the later of:

1) The Policy Effective Date; or
2) The date on which You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Enrollment:

How do I enroll for coverage?

All eligible Active Employees will be enrolled automatically by the Employer.

Evidence of Insurability:

What is Evidence of Insurability and what happens if Evidence of Insurability is not satisfactory to Us?

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

1) A completed and signed application approved by Us;
2) A medical examination, if requested;
3) Attending Physicians' statements; and
4) Any additional information We may require.

All Evidence of Insurability will be furnished at Our expense. We will then determine if You are insurable under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

1) Your Monthly Benefit will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Change in Family Status:

What constitutes a Change in Family Status?

A Change in Family Status occurs when:

1) You get married or You execute a domestic partner affidavit;
2) You and Your spouse divorce or You terminate a domestic partnership;
3) Your child is born, or You adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance; or

7) You have a change in classification from part-time to full-time or from full-time to part-time.

PERIOD OF COVERAGE

Effective Date:

When does my coverage start?

Your coverage will start on the date You become eligible.

Deferred Effective Date:

When will my effective date for coverage or a change in my coverage be deferred?

If You are absent from work due to:

1) Accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) Pregnancy;

On the date Your insurance, or increase in coverage, would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage:

Can I change my benefit options?

You may change Your benefit option at any time. You may decrease coverage or increase coverage to a higher option.

Any such increase in coverage is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre-existing Conditions Limitations.

Do coverage amounts change if there is a change in my class or my rate of pay?

Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) Are an Active Employee; and
2) Are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-Disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes The Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

1) The Deferred Effective Date provision; and
2) Pre-existing Conditions Limitations.

Continuity from a Prior Policy:

Is there continuity of coverage from a Prior Policy?

If You were:

1) Insured under the Prior Policy; and

2) Not eligible to receive benefits under the Prior Policy;

On the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

1) The Policy Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or

2) The date the restriction would have ceased to apply had the Prior Policy remained in force if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) The Monthly Benefit which was paid by the Prior Policy; or

2) The Monthly Benefit provided by The Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received monthly benefits for disability under the Prior Policy, and You returned to work as a Full-time or Part-time Active Employee before the Policy Effective Date, then, if within 6 months of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and

2) There are no benefits available for the recurrence under the Prior Policy;

The Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination:

When will my coverage end?

Your coverage will end on the earliest of the following:

1) The date The Policy terminates;

2) The date The Policy no longer insures Your class;

3) The date premium payment is due but not paid;

4) The last day of the period for which You make any required premium contribution;

5) The date Your Employer terminates Your employment; or

6) The date You cease to be a Full-time or Part-time Active Employee in an eligible class for any reason; unless continued in accordance with any of the Continuation Provisions.

Continuation Provisions:

Can my coverage be continued beyond the date it would otherwise terminate?

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) Is subject to any reductions in The Policy;

2) Is subject to payment of premium; and

3) Terminates if:
   a) The Policy terminates; or
   b) Coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Leave of Absence: If You are on a documented leave of absence, other than Military Leave of Absence, Your coverage may be continued for 12 month(s) from start date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Medical Leave of Absence: If You are on a documented medical leave of absence, Your coverage may be continued for up to 12 month(s) from the start date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 12 month(s) from the start date the leave of absence commenced. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled:

Does my insurance continue while I am Disabled and no longer an Active Employee?

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) During the Elimination Period while You remain Disabled by the same Disability; and
2) After the Elimination Period for as long as You are entitled to benefits under The Policy.

Waiver of Premium:

Am I required to pay premiums while I am Disabled?

No premium will be due for You:

1) After the Elimination Period; and
2) For as long as benefits are payable.

Extension of Benefits for Disability:

Do my benefits continue if The Policy terminates?

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) Will continue as long as You remain Disabled by the same Disability; but
2) Will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

BENEFITS

Disability Benefit:

What are my Disability Benefits under The Policy?

We will pay You a Monthly Benefit if You:

1) Become Disabled while insured under The Policy;
2) Are Disabled throughout the Elimination Period;

3) Remain Disabled beyond the Elimination Period; and

4) Submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

Mental Illness Limitation:

Are benefits limited for Mental Illness?

If You are Disabled because of:

1) Mental Illness that results from any cause; or

2) Any condition that may result from Mental Illness;

Then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

Benefits will be payable:

1) For as long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or

2) If not confined, or after You are discharged and still disabled, for a total of 24 months for all such disabilities during Your lifetime.

Specified Condition Limitation:

Are benefits limited for any specified conditions?

If You are Disabled because of any of the following conditions or symptom complexes:

1) Chronic fatigue conditions such as:
    a) Chronic fatigue syndrome;
    b) Chronic fatigue immunodeficiency syndrome;
2) Post viral syndrome;
3) Limbic encephalopathy;
4) Epstein-Barr virus infection;
5) Herpes virus type 6 infection;
6) Myalgic encephalomyelitis;
7) Any allergy or sensitivity to chemicals or the environment such as:
    a) Environmental allergies;
    b) Sick building syndrome;
    c) Multiple chemical sensitivity syndrome or chronic toxic encephalopathy;
8) Chronic pain conditions such as:
    a) Fibromyalgia;
    b) Reflex sympathetic dystrophy or myofascial pain;
    c) Carpal tunnel or repetitive motion syndrome;
    d) Temporomandibular joint disorder; or
    e) Craniomandibular joint disorder.

Specified Condition Limitation does not include neoplastic diseases, neurologic diseases, endocrine diseases, hematologic diseases, asthma, allergy-induced reactive lung disease, tumors, malignancies, or vascular malformations, demyelinating diseases, or lupus.

We will limit the Maximum Duration of Benefits, subject to all other provisions of The Policy.

Benefits will be payable until the earlier of:

1) The date benefit payments terminate under the Termination of Payment provision; or
2) The date You have received Disability benefit payments from Us for one or more of the diseases specified above for a total of 24 month(s) in Your lifetime.

The period of time referenced above will include the time that one or more of the specified diseases are the working diagnosis of the condition which is a cause of Your Disability.

Recurrent Disability:

What happens if I Recover but become Disabled again?

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are equal to 30 days or less.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

1) Due to the same cause; or
2) Due to a related cause; and
3) Within 6 months of the return to work;

The Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for 6 months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

Calculation of Monthly Benefit—Return to Work Incentive:

How are my Disability benefits calculated?

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:

1) Multiply Your Pre-Disability Earnings by the Benefit Percentage;
2) Compare the result with the Maximum Benefit; and
3) From the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12-consecutive month period will start on the last to occur of:

1) The day You first start work; or
2) The end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return-to-Work Incentive, We will calculate Your Monthly Benefit as follows:

1) Multiply Your Monthly Income Loss by the Benefit Percentage;
2) Compare the result with the Maximum Benefit; and
3) From the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Calculation of Monthly Benefit:

What happens if the sum of my Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of my Pre-disability Earnings?

If the sum of Your Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of Your Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

Minimum Monthly Benefit:

Is there a Minimum Monthly Benefit?

Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

Partial Month Payment:

How is the benefit calculated for a period of less than a month?

If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Termination of Payment:

When will my benefit payments end? Benefit payments will stop on the earliest of:

1) The date You are no longer Disabled;
2) The date You fail to furnish Proof of Loss;
3) The date You are no longer under the Regular Care of a Physician;
4) The date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) The date of Your death;
6) The date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) The last day benefits are payable according to the Maximum Duration of Benefits Table;
8) The date Your Current Monthly Earnings:
    a) Are equal to or greater than 80% of Your Indexed Pre-Disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
    b) Exceed 60% of Your Indexed Pre-Disability Earnings if You are receiving benefits for being Disabled from Any Occupation;
9) The date no further benefits are payable under any provision in The Policy that limits benefit duration; or
10) The date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:

a) Modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;

b) Adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;

c) Modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or

d) Adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;

provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

Family Care Credit Benefit:

What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?

If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

1) Family Care means the care or supervision of:
   a) Your children under age 13; or
   b) A member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2) The maximum monthly deduction allowed for each qualifying child or family member is:
   a) $350 during the first 12 months of Rehabilitation; and
   b) $175 thereafter;

   But in no event may the deduction exceed the amount of Your monthly earnings;
3) Family Care Credits may not exceed a total of $2,500 during a calendar year;
4) The deduction will be reduced proportionally for periods of less than a month;
5) The charges for Family Care must be documented by a receipt from the caregiver;
6) The credit will cease on the first to occur of the following:
   a) You are no longer in a Rehabilitation program; or
   b) Family Care Credits for 24 months have been deducted during Your Disability; and
7) No Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-Disability Earnings

Survivor Income Benefit:

Will my survivors receive a benefit if I die while receiving Disability Benefits?

If You were receiving a Monthly Benefit at the time of Your death, We will pay a Survivor Income Benefit, when We receive proof satisfactory to Us:

1) Of Your death; and

2) That the person claiming the benefit is entitled to it.

We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.

The Survivor Income Benefit will only be paid:

1) To Your Surviving Spouse; or

2) If no Surviving Spouse, in equal shares to Your Surviving Children. If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

The Survivor Income Benefit is calculated as 3 times the lesser of:

1) Your Monthly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or

2) The Maximum Monthly Benefit.

Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner provided You:

1) Have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or

2) Have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

Surviving Children means Your unmarried children, stepchildren, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance and who are under age 25.

The term Surviving Children will also include any other children related to You by blood or marriage or domestic partnership and who:

1) Lived with You in a regular parent-child relationship; and

2) Were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

Workplace Modification Benefit:

Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:

1) Your Disability is covered by The Policy;

2) The Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and

3) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such Workplace Modification shall not exceed $25,000.

We have the right, at Our expense, to have You examined or evaluated by:

1) A Physician or other health care professional; or

2) A vocational expert or rehabilitation specialist;

Of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

1) The proposed modifications made on Your behalf are complete;
2) We have been provided written proof of the expenses incurred to provide such modification; and
3) You have returned to work as an Active Employee.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of The Policy.

With Respect to Class 1:

Ability Plus Benefit:

What is the Ability Plus Benefit?

We will pay You the Ability Plus Benefit if:

1) A Monthly Benefit is payable;
2) You become Cognitively Impaired or unable to perform two or more Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:
   a) During or after the Elimination Period, and
   b) For at least 30 consecutive days; and
3) The Disability and such impairment or inability begins while You are covered under this benefit.

The Ability Plus Benefit will be 20% of Your Monthly Income Loss, but not greater than the lesser of:

1) $5,000; or
2) The Maximum Monthly Benefit.

We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Ability Plus Benefit for each day of covered loss. The Ability Plus Benefit is payable in addition to the Monthly Benefit payable under the Disability Benefit.

The Ability Plus Benefit will not:

1) Be reduced by Other Income Benefits;
2) Increase or reduce other benefits under The Policy; or
3) Be subject to the Cost-of-Living Adjustment.

You are not restricted in any way as to Your use of this Ability Plus Benefit.

We will stop paying You the Ability Plus Benefit on the date:

1) Your Monthly Benefit terminates;
2) You are not Cognitively Impaired, and You are able to perform five or more ADLs; or
3) You reach the maximum payment period shown in this benefit.

With Respect to Class 2:

Ability Plus Benefit:

What is the Ability Plus Benefit?

We will pay You the Ability Plus Benefit if:

1) A Monthly Benefit is payable;
2) You become Cognitively Impaired or unable to perform two or more Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:

a) During or after the Elimination Period, and

b) For at least 30 consecutive days; and

3) The Disability and such impairment or inability begins while You are covered under this benefit.

The Ability Plus Benefit will be 30% of Your Pre-Disability Earnings, but not greater than the lesser of:

1) $5,000; or

2) The Maximum Monthly Benefit.

We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Ability Plus Benefit for each day of covered loss. The Ability Plus Benefit is payable in addition to the Monthly Benefit payable under the Disability Benefit.

The Ability Plus Benefit will not:

1) Be reduced by Other Income Benefits; or

2) Increase or reduce other benefits under The Policy.

You are not restricted in any way as to Your use of this Ability Plus Benefit.

We will stop paying You the Ability Plus Benefit on the date:

1) Your Monthly Benefit terminates; or

2) You are not Cognitively Impaired, and You are able to perform five or more ADLs.

With Respect to Class 3:

Ability Plus Benefit:

What is the Ability Plus Benefit?

We will pay You the Ability Plus Benefit if:

1) A Monthly Benefit is payable;

2) You become Cognitively Impaired or unable to perform two or more Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:

a) During or after the Elimination Period, and

b) For at least 30 consecutive days; and

3) The Disability and such impairment or inability begins while You are covered under this benefit.

The Ability Plus Benefit will be 20% of Your Monthly Income Loss, but not greater than the lesser of:

1) $5000; or

2) The Maximum Monthly Benefit.

We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Ability Plus Benefit for each day of covered loss. The Ability Plus Benefit is payable in addition to the Monthly Benefit payable under the Disability Benefit.

The Ability Plus Benefit will not:

1) Be reduced by Other Income Benefits;

2) Increase or reduce other benefits under The Policy; or

3) Be subject to the Cost-of-Living Adjustment.

You are not restricted in any way as to Your use of this Ability Plus Benefit.

We will stop paying You the Ability Plus Benefit on the date:

1) Your monthly Benefit terminates;
2) You are not Cognitively Impaired, and You are able to perform five or more ADLs; or
3) You reach the maximum payment period shown in this benefit.

With Respect to Class 4:

Ability Plus Benefit:

What is the Ability Plus Benefit?

We will pay You the Ability Plus Benefit if:

1) A Monthly Benefit is payable;
2) You become Cognitively Impaired or unable to perform two or more Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:
    a) During or after the Elimination Period, and
    b) For at least 30 consecutive days; and
3) The Disability and such impairment or inability begins while You are covered under this benefit.

The Ability Plus Benefit will be 30% of Your Pre-Disability Earnings, but not greater than the lesser of:

1) $5,000; or
2) The Maximum Monthly Benefit.

We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Ability Plus Benefit for each day of covered loss. The Ability Plus Benefit is payable in addition to the Monthly Benefit payable under the Disability Benefit.

The Ability Plus Benefit will not:

1) Be reduced by Other Income Benefits; or
2) Increase or reduce other benefits under The Policy.

You are not restricted in any way as to Your use of this Ability Plus Benefit.

We will stop paying You the Ability Plus Benefit on the date:

1) Your Monthly Benefit terminates; or
2) You are not Cognitively Impaired, and You are able to perform five or more ADLs.

Cognitively Impaired means You suffer severe deterioration, or loss of:

1) Memory;
2) Orientation; or
3) The ability to understand or reason;

so that You are unable to perform common tasks such as, but not limited to, medication management, money management and using the telephone. The impairment in intellectual capacity must be measurable by standardized tests.

Activities of Daily Living (ADLs) means the following functions performed with or without equipment or adaptive devices:

1) Bathing Yourself by being able to either:
    a) Wash Yourself in a tub or shower devices; or
    b) Give Yourself a sponge bath;

2) Dressing Yourself by putting on and taking off needed garments and any braces or artificial limbs necessary for You to wear;
3) Using the toilet by being able to get to and from, and on and off the toilet, and performing the associated hygienic tasks; or
4) Transferring from bed to chair or wheelchair; or
5) Bladder and bowel control by being able to either:
   a) Voluntarily control bowel and bladder function; or
   b) Maintain a reasonable level of personal hygiene if You are not so able; and
6) Feeding Yourself once the food has been prepared and made available to You.

EXCLUSIONS AND LIMITATIONS

Exclusions:

What Disabilities are not covered?

The Policy does not cover, and We will not pay a benefit for, any Disability:

1) Unless You are under the Regular Care of a Physician;
2) That is caused or contributed to by war or act of war, whether declared or not;
3) Caused by Your commission of or attempt to commit a felony;
4) Caused or contributed to by Your being engaged in an illegal occupation; or
5) Caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

6) Was sponsored by Your Employer; and
7) Was terminated before the Effective Date of The Policy; no benefits will be payable for the Disability under The Policy.

With Respect to Class 1:

Pre-existing Condition Limitation:

Are benefits limited for Pre-existing Condition?

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for 3 consecutive month(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 12 consecutive month(s).

With Respect to Class 2:

Pre-existing Condition Limitation:

Are benefits limited for Pre-existing Conditions?

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for 6 consecutive month(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 24 consecutive month(s).

With Respect to Class 3:

Pre-existing Condition Limitation:

Are benefits limited for Pre-existing Condition?

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for 3 consecutive month(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 12 consecutive month(s).

With Respect to Class 4:

Pre-existing Condition Limitation:

Are benefits limited for Pre-existing Conditions?

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for 6 consecutive month(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 24 consecutive month(s).

With Respect to Class 1:

Pre-existing Condition means:

1) Any accidental bodily injury, sickness, Mental Illness, pregnancy, episode of Substance Abuse, or Other Limited Conditions; or
2) Any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, Substance Abuse, or Other Limited Conditions;

For which You received Medical Care during the 3-consecutive month(s) period that ends the day before:

1) Your effective date of coverage; or
2) The effective date of a Change in Coverage.

With Respect to Class 2:

Pre-existing Condition means:

1) Any accidental bodily injury, sickness, Mental Illness, pregnancy, episode of Substance Abuse, or Other Limited Conditions; or
2) Any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, Substance Abuse, or Other Limited Conditions;

for which You received Medical Care during the 6-consecutive month(s) period that ends the day before:

1) Your effective date of coverage; or
2) The effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1) Is consulted or gives medical advice; or
2) Recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) Medical examinations, tests, attendance or observation; and

2) Use of drugs, medicines, medical services, supplies or equipment.

With Respect to Class 3:

Pre-existing Condition means:

1) Any accidental bodily injury, sickness, Mental Illness, pregnancy, episode of Substance Abuse, or Other Limited Conditions; or

2) Any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, Substance Abuse, or Other Limited Conditions;

for which You received Medical Care during the 3-consecutive month(s) period that ends the day before:

1) Your effective date of coverage; or

2) The effective date of a Change in Coverage.

With Respect to Class 4:

Pre-existing Condition means:

1) Any accidental bodily injury, sickness, Mental Illness, pregnancy, episode of Substance Abuse, or Other Limited Conditions; or

2) Any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, Substance Abuse, or Other Limited Conditions;

for which You received Medical Care during the 6-consecutive month(s) period that ends the day before:

1) Your effective date of coverage; or

2) The effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1) Is consulted or gives medical advice; or

2) Recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) Medical examinations, tests, attendance or observation; and

2) Use of drugs, medicines, medical services, supplies or equipment.

GENERAL PROVISIONS

Notice of Claim:

When should I notify the Company of a claim?

You must give Us written notice of a claim within 30 days after Disability or loss occurs. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Such notice must include Your name, Your address and the Policy Number.

If You are Disabled and become eligible for the Ability Plus Benefit, You must file a separate Notice of Claim within 30 days of becoming eligible.

Claim Forms:

Are special forms required to file a claim?

We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

Proof of Loss:

What is Proof of Loss?

Proof of Loss may include but is not limited to the following:

1) Documentation of:
   a) The date Your Disability began;
   b) The cause of Your Disability;
   c) The prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) Evidence that You are under the Regular Care of a Physician;
2) Any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) The names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) Hospitals or other medical facilities in which You have been treated; and
   c) Pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
   a) Medical, employment and financial information; and
   b) Any other information We may reasonably require;
5) Disclosure of all information and documentation required by Us relating to Other Income Benefits;
6) Proof that You and Your dependents have applied for all Other Income Benefits which are available; and
7) Disclosure of all information and documentation required by Us in order to exercise Our Subrogation or Reimbursement rights.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

Additional Proof of Loss:

What Additional Proof of Loss is the Company entitled to?

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) Meet and interview with Our representative; and
2) Be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) At Our expense; and
2) As reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

Sending Proof of Loss:

When must Proof of Loss be given?

Written Proof of Loss must be sent to Us within 90 days following the completion of the Elimination Period. If proof is not given by the time it is due, it will not affect the claim if:

1) It was not reasonably possible to give proof within the required time; and
2) Proof is given as soon as reasonably possible; but
3) Not later than 1 year after it is due unless You are not legally competent.

We may request Proof of Loss throughout Your Disability, as reasonably required. In such cases, We must receive the proof within 30 day(s) of the request.

Claim Payment:

When are benefit payments issued?

When We determine that You;

1) Are Disabled; and
2) Eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

Benefits may be subject to interest payments as required by applicable law.

Claims to be Paid:

To whom will benefits for my claim be paid?

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) A person who is a minor; or
3) A person who is not legally competent;

Then We may pay up to $1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial:

What notification will I receive if my claim is denied?

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) Give the specific reason(s) for the denial;
2) Make specific reference to The Policy provisions on which the denial is based;
3) Provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) Provide an explanation of the review procedure.

Claim Appeal:

What recourse do I have if my claim is denied?

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

1) Must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) May request copies of all documents, records, and other information relevant to Your claim; and
3) May submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

Social Security:

When must I apply for Social Security Benefits?

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) To follow the process established by the Social Security Administration to reconsider the denial; and
2) If denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Benefit Estimates:

How does the Company estimate Disability benefits under the United States Social Security Act?

We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive.

When We determine that You or Your dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

1) You or Your dependent are later awarded Social Security disability benefits, We will adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than We estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security benefits were higher than We estimated, and if Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.

Overpayment:

When does an overpayment occur?

An overpayment occurs:

1) When We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or

2) When payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) Retroactive awards received from sources listed in the Other Income Benefits definition;

2) Failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;

3) Misstatement;

4) Fraud; or

5) Any error We may make.

Overpayment Recovery:

How does the Company exercise the right to recover overpayments?

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

1) Recover such overpayments from:
   a) You;
   b) Any other organization;
   c) Any other insurance company;
   d) Any other person to or for whom payment was made; and
   e) Your estate;
2) Reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) Refer Your unpaid balance to a collection agency; and
4) Pursue and enforce all legal and equitable rights in court.

Subrogation:

What are Our subrogation rights? If You:

1) Suffer a Disability caused, in full or in part, by the act or omission of any person or legal entity;

2) Become entitled to and are paid benefits under The Policy in compensation for lost wages; and

3) Do not initiate legal action for the recovery of such benefits from a Third Party in a reasonable period of time or notify Us that You do not intend to do so;

then We will be subrogated to any rights You may have against a Third Party and may, at Our option, bring legal action against or otherwise pursue a Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means:

1) Any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or

2) Any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Reimbursement:

What are Our reimbursement rights?

We have the right to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover any funds from a Third Party.

If You recover any funds from a Third Party as:

1) A legal judgment;

2) An arbitration award; or

3) A settlement or otherwise;

You or Your attorney shall hold in constructive trust the lesser of:

1) The entire amount of the benefit payment(s) made or required to be made by Us; or

2) The total amount of the recovered funds;

less Our pro rata share of any reasonable attorneys' fees and court costs associated with the recovered funds. We have the right of first reimbursement regardless of:

1) Whether You are made whole;

2) How the recovered funds are characterized; or

3) Whether the particular funds recovered are still in Your possession.

By accepting benefit payment(s) under The Policy, You:

1) Agree to cooperate fully with Our reimbursement rights, including disclosure of all information and documentation required by Us in order to exercise Our reimbursement rights; and

2) Will not do anything to prejudice Our reimbursement rights.

You or Your attorney's failure to cooperate fully with Our reimbursement rights may result in denial or termination of Your benefits under The Policy.

Third Party as used in this provision, means:

1) Any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or

2) Any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Legal Actions:

When can legal action be taken against Us?

Legal action cannot be taken against Us:

1) Sooner than 60 days after the date Proof of Loss is given; or

2) More than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud:

How does the Company deal with fraud?

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter

and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

Misstatements:

What happens if facts are misstated?

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and

2) The true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement, except fraudulent misstatements, made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

All statements made by the Policyholder, the Employer or You under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

Eligibility Determination:

How will We determine Your eligibility for benefits?

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your beneficiaries' eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:

1) Obtain with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;

2) Consider and interpret The Policy and all information obtained by Us and submitted by You that relates to Your claim for benefits and make Our determination of Your eligibility for benefits based on that information and in accordance with The Policy and applicable law;

3) If We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;

4) If We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled Claim Denial.

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled Claim Appeal. If You do not appeal the decision to Us, then the decision will be Our final decision.

Physical Examinations and Autopsy:

Will I be examined during the course of my claim?

While a claim is pending, We have the right at Our expense:

1) To have the person who has a loss examined by a Physician when and as often as reasonably necessary; and

2) To make an autopsy in case of death where it is not forbidden by law.

DEFINITIONS

Actively at Work means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) In the usual way; and

2) For Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Any Occupation means any occupation for which You are qualified by education, training or experience, and that has an earnings potential greater than the lesser of:

1) 60% of Your Indexed Pre-Disability Earnings; or

2) The Maximum Monthly Benefit.

Current Monthly Earnings means monthly earnings You receive from:

1) Your Employer; and

2) Other employment; while You are Disabled.

However, if the other employment is a job You held in addition to Your job with Your Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6-month period just before You became Disabled will count as Current Monthly Earnings.

Current Monthly Earnings also includes the pay You could have received for another job or a modified job if:

1) Such job was offered to You by Your Employer, or another employer, and You refused the offer; and

2) The requirements of the position were consistent with:

    a) Your education, training and experience; and

    b) Your capabilities as medically substantiated by Your Physician.

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation during the Elimination Period;

2) Your Occupation, for the 24 months following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-Disability Earnings; and

3) After that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first. For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by Your Employer, or another employer, and You refused the offer.

Your Disability must result from:

1) Accidental bodily injury;

2) Sickness;

3) Mental Illness;

4) Substance Abuse; or

5) Pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that You are Disabled.

Elimination Period means the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Employer sponsored short term disability benefits or salary continuation program, excluding benefits required by state law.

Employer means the Policyholder.

Essential Duty means a duty that:

1) Is substantial, not incidental;

2) Is fundamental or inherent to the occupation; and

3) Cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

Indexed Pre-disability Earnings means Your Pre-Disability Earnings adjusted annually by adding the lesser of:

1) 10%; or

2) The percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is comparable to the CPI-W.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Mental Retardation;

2) Pervasive Developmental Disorders;

3) Motor Skills Disorder;

4) Substance-Related Disorders;

5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or

6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.

Monthly Income Loss means Your Pre-Disability Earnings minus Your Current Monthly Earnings.

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You or Your family, or to a third party on Your behalf, pursuant to any:

1) Temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;

2) Governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;

3) Plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;

4) Mandatory "no-fault" automobile insurance plan;

5) Disability benefits under:

   a) The United States Social Security Act or alternative plan offered by a state or municipal government;

   b) The Railroad Retirement Act;

   c) The Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or

   d) Similar plan or act;

   that You, Your spouse and/or children, are eligible to receive because of Your Disability; or

6) Disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:

   a) That begins after You become Disabled; or

   b) That You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means the amount of any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) Disability benefit under Your Employer's Retirement Plan;

2) Temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;

3) Portion of a judgement or settlement of a claim or lawsuit that represents or compensates for Your loss of earnings, less Our pro rata share of any associated reasonable attorneys' fees and court costs;

4) Retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:

   a) You were receiving it prior to becoming Disabled; or

   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or

5) Retirement benefits under:

   a) The United States Social Security Act or alternative plan offered by a state or municipal government;

   b) The Railroad Retirement Act;

   c) The Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or

   d) Similar plan or act;

   that You, Your spouse and/or children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1) The amount attributed to loss of income; and

2) The period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, and the time period to be 24 month(s). We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) Takes effect after the date benefits become payable under The Policy; and

2) Is a general increase which applies to all persons who are entitled to such benefits.

Physician means a person who is:

1) A Doctor of Medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;

2) Licensed to practice in the jurisdiction where care is being given;

3) Practicing within the scope of that license; and

4) Not You or Related to You by blood or marriage.

Pre-disability Earnings means Your regular annual rate of pay in effect on the last day You were Actively at Work before You became Disabled, including:

1) Contributions You make through a salary reduction agreement with the Employer to:

   a) An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p) or 457 deferred compensation arrangement;

   b) An executive non-qualified deferred compensation arrangement; or

   c) A salary reduction arrangement under an IRC Section 125 plan; plus

2) Annual target incentives expected to be paid by Your Employer in effect on the last day You were Actively at Work before You became Disabled;

divided by 12.

Pre-disability Earnings does not include bonuses, commissions, tips and tokens, overtime pay or any other fringe benefits or extra compensation.

Annual target incentives:

1) Apply to incentive-eligible employees with a career band designated as SL, customer and frontline experience roles in T-Mobile for Business, and Customer Experience Center employees with a monthly incentive plan (i.e. not an annual corporate bonus plan); and

2) Are listed in the Employer's HR system. If You are part-time, Your annual incentive listed in the HR system will be prorated based on Your Full-time Employment percent.

Prior Policy means the long-term disability insurance carried by the Employer on the day before the Policy Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) Whose medical training and clinical experience are suitable to treat Your disabling condition; and

2) Whose treatment is:

   a) Consistent with the diagnosis of the disabling condition;

   b) According to guidelines established by medical, research, and rehabilitative organizations; and

   c) Administered as often as needed; to achieve the maximum medical improvement.

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return-to-work needs. A Rehabilitation program may include, when We consider it to be appropriate, any necessary and feasible:

1) Vocational testing;

2) Vocational training;
3) Alternative treatment plans such as:
    a) Support groups;
    b) Physical therapy;
    c) Occupational therapy; or
    d) Speech therapy;
4) Work-place modification to the extent not otherwise provided;
5) Job placement;
6) Transitional work; and
7) Similar services.

Related means Your spouse, or someone in a similar relationship in law to You, or other adult living with You, or Your sibling, parent, stepparent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) A profit-sharing plan;
2) Thrift, savings or stock ownership plans;
3) A non-qualified deferred compensation plan; or
4) An individual retirement account (IRA), a tax-sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) Impairments in social and/or occupational functioning;
2) Debilitating physical condition;
3) Inability to abstain from or reduce consumption of the substance; or
4) The need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

The Policy means the policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Our, or Us means the insurance company named on the face page of The Policy.

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

You or Your means the person to whom this certificate is issued.

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

STATE NOTICES

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at **https://www.thehartford.com/**. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable

Arizona:

1) **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1) **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

   Arkansas Insurance Department
   1 Commerce Way, Suite 102
   Little Rock, AR 72202

2) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

California:

1) **NOTICE:** READ YOUR CERTIFICATE CAREFULLY

   You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30-day period will be deducted from the refund.

   PLEASE BE ADVISED THAT YOU RETAIN ALL RIGHTS WITH RESPECT TO YOUR POLICY/CERTIFICATE AGAINST YOUR ORIGINAL INSURER IN THE EVENT THE ASSUMING INSURER IS UNABLE TO FULFILL ITS OBLIGATIONS. IN SUCH EVENT YOUR ORIGINAL INSURER REMAINS LIABLE TO YOU NOTWITHSTANDING THE TERMS OF ITS ASSUMPTION AGREEMENT.

2) The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

   Eligibility Determination:

   How will We determine Your eligibility for benefits?

   We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility or Your beneficiaries for benefits for any claim You or Your beneficiaries make on The Policy. We will:

   1. Obtain with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
   2. As a part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
   3. If We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
   4. If We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal**. If You do not appeal the decision to Us, then the decision will be Our final decision.

3) For Your Questions and Complaints:

State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833
Web Address: www.insurance.ca.gov

Colorado:

1) The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.

2) The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions.

3) Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.

4) The **Complications of Pregnancy** provision, if shown in the **Definitions** section of the Certificate, is revised as follows:

   Complications of Pregnancy means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:

   1. Acute nephritis or nephrosis;
   2. Cardiac decompensation;
   3. Missed abortion; and
   4. Similar medical and surgical conditions of comparable severity.

   Complications of Pregnancy will also include:

   1. Pre-eclampsia;
   2. Placenta previa;
   3. Physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;
   4. Termination of ectopic pregnancy;
   5. Spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible;
   6. Non-elective Cesarean section; and
   7. Similar medical and surgical conditions of comparable severity.

   However, the term Complications of Pregnancy will not include:

   1. Elective Cesarean section;
   2. False labor, occasional spotting, or morning sickness;
   3. Hyperemesis gravidarum; or
   4. Similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.

5) The **Claim Appeal** provision will always include the following:

   In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

6) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Florida:

1) **NOTICE:** The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.

Georgia:

1) **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1) For Your Questions and Complaints:

Idaho Department of Insurance
Consumer Affairs

700 W State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043
Toll Free: 1-800-721-3272
Web Address: www.DOI.Idaho.gov

1) NOTICE TO BUYER: THIS IS A DISABILITY INCOME PROTECTION POLICY.

2) The **Elimination Period** provision, shown in the Schedule of Insurance section of the Certificate, cannot exceed:

   a) 90 days for plan designs with a **Maximum Duration of Benefits Payable** of 1 year or less;

   b) 180 days for plan designs with a **Maximum Duration of Benefits Payable** of more than 1 year but less than 2 years; or

   c) 365 days for plan designs with a **Maximum Duration of Benefits Payable** of 2 years or more.

3) The **Maximum Duration of Benefits Payable** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot be less than 6 months.

Illinois:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

2) For Your Questions and Complaints:

Illinois Department of Insurance
Consumer Services Station
Springfield, Illinois 62767
Consumer Assistance: 1(866) 445-5364
Officer of Consumer Health Insurance: 1(877) 527-9431

3) In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 et seq. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at www.insurance.illinois.gov.

Indiana:

1) For Your Questions and Complaints:

Public Information/Market Conduct
Indiana Department of Insurance
311 W. Washington St. Suite 300
Indianapolis, IN 46204-2787
1 (317) 232-2395

Kansas:

1) The following requirement applies to you:

   Policy Interpretation:

   Who interprets Policy terms and conditions?

   Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are a fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

Louisiana:

1) The following requirement is applicable to you:

   Reinstatement after Military Service:

   Can coverage be reinstated after return from active military service?

   If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

   The reinstated coverage will:

   1. Be the same coverage amounts in force on the date coverage ended;
   2. Not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
   3. Be subject to all the terms and provisions of The Policy.

Maine:

1) **NOTICE:** The benefits under the policy are subject to reduction due to other sources of income.

   This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under the policy.

   Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker's Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.

   What comprises other sources of income under the policy is determined by the nature of the policyholder. Therefore, we strongly urge you to **Read Your Certificate Carefully**. A full description of the plans and types of plans considered to be other sources of income under the policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.

2) **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third-Party Notice Request Form shall be mailed or personally delivered to the insured.

3) The following **requirement is applicable to you**:

Reinstatement:

Can my coverage be reinstated after it ends?

We will reinstate The Policy upon receipt of all current and late premiums if:

1. You, any person authorized to act on Your behalf, or any of Your dependents may request reinstatement of The Policy within 90 days following cancellation of The Policy for nonpayment of premium provided You suffered from cognitive impairment or functional incapacity at the time the contract cancelled; and
2. All current and late premium payments are received within 15 days of Our request.

We may request a medical demonstration, at Your expense, that You suffered from cognitive impairment or functional incapacity at the time of cancellation of The Policy.

Massachusetts:

1) The **Surviving Children** definition in the **Survivor Income Benefit** will also include a child in the process of adoption.
2) The following continuation requirement is applicable to you

   In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates, or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31-day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first. You must pay the required premium for continued coverage.

   Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:

   1. 90 days from the date You were no longer eligible for coverage as a Full-time Active Employee;
   2. The date You become eligible for similar benefits under another group plan;
   3. The last day of the period for which required premium is made;
   4. The date the group insurance policy terminates; or
   5. The date Your Employer ceases to be a Participant Employer, if applicable.

Michigan:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Missouri:

1) The **Exclusions** provision shall only exclude for intentionally self-inflicted Injury, suicide or attempted suicide, which occur while You are sane.

Montana:

1) **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate
2) Pregnancy will be covered, the same as any other sickness, anything in The Policy to the contrary notwithstanding.
3) The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for treatment within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist,

podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1) If Your claim is denied, You may appeal to Us within 180 days of receipt of the claim denial, subject to the other terms of the **Claim Appeal** provision.
2) The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section cannot be less than 3 years after the time **Proof of Loss** is required to be given.
3) The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Exclusions and Limitations** section, is 3 consecutive months. No benefit or increase in benefits for a **Pre- existing Condition** will be payable until You have been treatment free or continuously insured for 9 consecutive months, or less respectively, if shown in the Certificate.
4) Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
5) **Notice:** This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.
6) **Notice: READ YOUR CERTIFICATE CAREFULLY**—You have a 30 day right to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days from the later of Your original Certificate Effective Date or the date The Policy was received by the Policyholder. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30-day period will be deducted from the refund.
7) **Notice:** The Policy does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.

New Jersey:

1) The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2) The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions and domestic partners, provided You continue to meet the requirements described in the domestic partner affidavit, civil union license or civil union certificate or as required by law. Same sex relationships entered into under the laws of another State or Country, which closely approximate a civil union or a domestic partnership under New Jersey law, will be recognized as civil unions or domestic partners under New Jersey law.

New Mexico:

1) The **Surviving Children** definition within the **Survivor Income Benefit**, if included in Your Certificate, will include children up to age 26.

New York:

1) The **Other Income Benefits** definition will not include a portion of a settlement or judgment of a lawsuit that represents or compensates for Your loss of earnings.
2) The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3) The **Reimbursement** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
4) If the definition of **Surviving Spouse** within the **Survivor Income Benefit** requires the completion of a domestic partner affidavit, the following requirement applies to you:

   The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:

   1. You are both are legally and mentally competent to consent to contract in the state in which you reside;

2. You are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
3. You have been living together on a continuous basis prior to the date of the application;
4. Neither of you have been registered as a member of another domestic partnership within the last six months; and
5. You provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

1. A joint bank account;
2. A joint credit card or charge card;
3. Joint obligation on a loan;
4. Status as an authorized signatory on the partner's bank account, credit card or charge card;
5. Joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
6. Listing of both partners as tenants on the lease of the shared residence;
7. Shared rental payments of residence (need not be shared 50/50);
8. Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
9. A common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
10. Shared household budget for purposes of receiving government benefits;
11. Status of one as representative payee for the other's government benefits;
12. Joint responsibility for child care (e.g., school documents, guardianship);
13. Shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
14. Execution of wills naming each other as executor and/or beneficiary;
15. Designation as beneficiary under the other's life insurance policy;
16. Designation as beneficiary under the other's retirement benefits account;
17. Mutual grant of durable power of attorney;
18. Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
19. Affidavit by creditor or other individual able to testify to partners' financial interdependence;
20. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1) The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2) The **Other Income Benefits** definition will not include a mandatory "no-fault" automobile insurance plan.
3) You are not required to be under the **Regular Care of a Physician** if qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
4) The **Exclusions** provision shall only exclude for Workers' Compensation if the final adjudication of the Worker's Compensation claim determined that benefits are paid, or may be paid, if duly claimed.
5) Within the **Misstatements** provision reference to fraudulent misstatements will not apply to You.
6) The **Sending Proof of Loss** provision is amended to state that written **Proof of Loss** must be sent to Us within 180 days following the completion of the **Elimination Period**.

7) The **Claims to be Paid** provision is amended to state that We may pay up to $3,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

8) **Notice of Claim** may also be given to Our representative, if applicable.

9) **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD-PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:

   1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND

   2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION
YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

PRE-EXISTING LIMITATION
READ CAREFULLY

NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THE CERTIFICATE.

READ YOUR CERTIFICATE CAREFULLY.

Oregon:

1) The definition of **Surviving Spouse** within the **Survivor Income Benefit** will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.

2) The **Surviving Children** definition within the **Survivor Income Benefit** will include children related to You by domestic partnership.

3) The following **Jury Duty** continuation applies for Employers with 10 or more employees:

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

   1. Elected to have Your coverage continued; and

   2. Provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1) The **Physical Examinations and Autopsy** provision will state that such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.

2) If You become insured under The Policy on the Policy Effective Date and were insured under the Prior Policy within 30 days of being covered under The Policy, the **Pre-existing Condition Limitation** will end on the earliest of:

   1. the Policy Effective date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or

   2. the date the restriction would have ceased to apply had the Prior Policy remained in force if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

   This is subject to the other terms and conditions of the **Continuity From a Prior Policy** provision.

South Dakota:

1) The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

2) The **Other Income Benefits** definition will not include the amount of any benefit for loss of income, provided to Your family, Your Spouse or Your Spouse's family.

Texas:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

2) NOTICE:

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call:
Customer Service: 1-860-547-5000
Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford

Email: GBD.Customerservice@hartfordlife.com

Mail:
The Hartford
Group Benefits Division
P.O. Box 2999
Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question:
1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail:
MC 111-1A
P.O. Box 12030
Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000
Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford
Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal:
The Hartford
Group Benefits Division
P.O. Box 2999
Hartford, CT 06104

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al:
1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal:
MC 111-1A
P.O. Box 12030
Austin, TX 78711-2030

Utah:

1) If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.

Vermont:

1) The following requirement applies:

   Purpose: Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

   Definitions, Terms, Conditions and Provisions: The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

   1. Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms, include the relationship created by a civil union established according to Vermont law.

2. Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

3. Terms that mean or refer to family relationships arising from a marriage, such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.

4. "Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

5. "Child or covered child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under the policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

2) Vermont Mental Health and Substance Abuse Exclusion and Limitation Parity:

If You become Disabled as a legal resident of Vermont and The Policy covers 25 or more legal residents of Vermont, the following applies:

a) Disability due to Mental Illness or Substance Abuse may not be excluded from coverage; and

b) The Maximum Duration of Benefits for Disability due to Mental Illness or Substance Abuse may not be limited. The Maximum Duration of Benefits shown in the Schedule of Insurance shall apply to You.

Virginia:

1) For Your Questions and Complaints:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209
1(804) 371-9691 (Local number)
1(800) 552-7945 (Virginia toll free number)
1(877) 310-6560 (National toll-free number)

Washington:

1) The following continuation applies to you:

General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage for a period not exceeding 6 months. If the work stoppage ends, this continuation will cease immediately.

Wisconsin:

1) For Your Questions and Complaints:

To request a Complaint Form:
Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1(800) 236-8517 (outside of Madison)
1(608) 266-0103 (in Madison)

ERISA INFORMATION

THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

1) Plan Name

T-MOBILE USA, INC. EMPLOYEE BENEFIT PLAN.

2) Plan Number

LTD – 506

3) Employer / Plan Sponsor

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

4) Employer Identification Number

91-1983600

5) Type of Plan

Welfare Benefit Plan providing Group Long Term Disability.

6) Plan Administrator

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

7) Agent for Service of Legal Process

For the Plan:

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

8) Sources of Contributions (Long Term Disability)

The Employer pays the premium for the insurance but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation. Any amounts paid by employees may be used to pay any benefit or expense under the plan.

9) Type of Administration

The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

10) The Plan and its records are kept on a Policy year basis.

11) Labor Organizations

None

12) Names and Addresses of Trustees

None

13) Plan Amendment Procedure

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF 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), as amended. ERISA provides that all Plan participants shall be entitled to:

1) Receive Information About Your Plan and Benefits

a) 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.

b) 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.

c) 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.

2) 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.

3) 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

4) 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 (formerly known as the Pension and Welfare Benefits 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.

Claim Procedures

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits:

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. 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 the Insurance Company receives your response to our request. If the Insurance Company 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 include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) 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 medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company

do not exist; 9) 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 for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits:

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

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

The Insurance Company's review on appeal 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.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45-day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it 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 Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit 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 Insurance Company 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 benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or

vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) 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 medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability:

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits:

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits:

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

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

The Insurance Company's review on appeal 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.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) 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 the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet is Insured by the

Hartford Life and Accident Insurance Company
Hartford, Connecticut
Member of The Hartford Insurance Group

Group Term Life Insurance with Accelerated Benefit

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

CERTIFICATE OF INSURANCE

Policyholder: T-MOBILE USA, INC.

Policy Number: GL-402610

Policy Effective Date: June 1, 2013

Policy Anniversary Date: January 1, 2021

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

ACCELERATED BENEFITS UNDER THIS CERTIFICATE DO NOT, AND ARE NOT INTENDED TO, QUALIFY AS LONG-TERM CARE UNDER WASHINGTON STATE LAW. WASHINGTON STATE LAW PREVENTS ACCELERATED LIFE BENEFITS FROM BEING MARKETED OR SOLD AS LONG-TERM CARE

IF YOU OR YOUR DEPENDENT RECEIVE PAYMENT OF ACCELERATED BENEFITS UNDER THIS CERTIFICATE, YOU OR YOUR DEPENDENT MAY LOSE THE RIGHT TO RECEIVE CERTAIN PUBLIC FUNDS SUCH AS MEDICARE, MEDICAID, SOCIAL SECURITY, SUPPLEMENTAL SECURITY, SUPPLEMENTAL SECURITY INCOME AND POSSIBLY OTHERS.

ANY BENEFITS RECEIVED UNDER THE ACCELERATED BENEFIT PROVISION MAY BE TAXABLE. YOU OR YOUR DEPENDENT SHOULD CONSULT A PERSONAL TAX ADVISOR FOR FURTHER INFORMATION.

Signed for the Company

Kevin Barnett, Secretary **Jonathan Bennett, President**

A note on capitalization in this Certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

SCHEDULE OF INSURANCE

The benefits described herein are those in effect as of January 1, 2021.

Cost of Coverage:

Non-Contributory Coverage: Basic Life Insurance

Contributory Coverage: Supplemental Life Insurance
Supplemental Dependent Life Insurance

Disclosure of Fees:

We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:

In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Disclosure of Payment to the Policyholder:

We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:

1) Audit;
2) Marketing communication services; and
3) Other administrative expenses.

Eligible Class(es) For Coverage:

All Full-time and Part-time 1 Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees as follows:

Class 1: All Full-time Active Employees
Class 2: All Part-time Active Employees

Full-time Employment: At least 30 scheduled hours weekly
Part-time Employment: At least 20 scheduled hours weekly

Annual Enrollment Period:

As determined by Your Employer on a yearly basis.

With respect to Basic Life Insurance:

Eligibility Waiting Period for Coverage:

None

With respect to Supplemental Life Insurance and Supplemental Dependent Life Insurance:

Eligibility Waiting Period for Coverage:

The first day of the month following 30 day(s) of employment.

The time period(s) referenced above are continuous. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer under the Prior Policy.

Life Insurance Benefit:

Amount of Life Insurance:

Basic Amount of Life Insurance

Maximum Amount

1.5 times Your annual Earnings, subject to a maximum of $1,000,000 rounded to the next higher $1,000 if not already a multiple of $1,000.

Supplemental Amount of Life Insurance

Guaranteed Issue Amount	Maximum Amount
3 times Your annual Earnings, subject to a maximum of $750,000 rounded to the next higher $1,000 if not already a multiple of $1,000.	1, 2, 3, 4, 5, 6, 7, or 8 times Your annual Earnings, subject to a maximum of $2,000,000 rounded to the next higher $1,000 if not already a multiple of $1,000.

Dependent Life Insurance Benefit:

Supplemental Amount of Dependent Life Insurance

	Guaranteed Issue Amount	Maximum Amount
Option 1: Spouse	$10,000	$10,000
Option 2: Spouse	$50,000	$50,000
Option 3: Spouse	$50,000	$100,000
Option 4: Spouse	$50,000	$150,000
Option 5: Spouse	$50,000	$200,000
Option 6: Spouse	$50,000	$250,000
Option 7: Spouse	$25,000	$25,000
Option 8: Spouse	$50,000	$75,000

		Maximum Amount
Option 1:	Dependent Children: live birth but under age 26 year(s)	$10,000
Option 2:	Dependent Children: live birth but under age 26 year(s)	$20,000

The amount of Spouse Supplemental coverage may never exceed 100% of the Combined Basic and Supplemental Amount of Life Insurance in force for the employee.

Reduction in Amount of Life Insurance:

We will reduce the Amount of Life Insurance for You and Your Dependents by any Amount of Life Insurance in force, paid or payable:

1) In accordance with the Conversion Right;
2) Under the Portability provision; or
3) Under the Prior Policy.

Reduction in Coverage Due to Age:

We will reduce the Life Insurance Benefit for You by 35% on the Policy Anniversary Date following the date You attain age 70 and 50% when You attain age 75. The reduction will apply to the Amount of Life Insurance in force immediately prior to the first reduction made. The reduced amount of coverage will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. An appropriate adjustment in premium will be made.

Reductions also apply if:

1) You become covered under The Policy; or
2) Your coverage increases;

on or after the date You attain age 70.

ELIGIBILITY AND ENROLLMENT

Eligible Persons:

Who is eligible for coverage?

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage:

When will I become eligible?

You will become eligible for coverage on the latest of:

1) The Policy Effective Date;
2) The date You become a member of an Eligible Class; or
3) The date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Eligibility for Dependent Coverage:

When will I become eligible for Dependent Coverage?

You will become eligible for Dependent coverage on the later of:

1) The date You become eligible for employee coverage; or
2) The date You acquire Your first Dependent.

No person may be insured as a Dependent and an Active Employee under The Policy.

Enrollment:

How do I enroll for coverage?

For Non-Contributory Coverage, Your Employer will automatically enroll You for coverage. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must:

1) Complete and sign a group insurance enrollment form which is satisfactory to Us, for Your and Your Dependent's coverage; and
2) Deliver it to Your Employer.

You have the option to enroll electronically. Your Employer will provide instructions.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll You may enroll for Your coverage and/or Your Dependent's coverage only:

1) During an Annual Enrollment Period designated by the Policyholder; or
2) Within 31 days of the date You have a Change in Family Status.

Enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements:

When will I first be required to provide Evidence of Insurability?

We require Evidence of Insurability for initial coverage, if You enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage.

If Your Evidence of Insurability is not satisfactory to Us, Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability.

We require Evidence of Insurability for initial coverage if You:

1) Enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) Enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) Were eligible for any coverage under the Prior Policy but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Evidence of Insurability:

What is Evidence of Insurability?

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

1) A completed and signed application approved by Us;
2) A medical examination;
3) An attending Physician's statement; and
4) Any additional information We may require.

Evidence of Insurability will be furnished at Our expense except for Evidence of Insurability due to late enrollment. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage as described in the Increase in Amount of Life Insurance provision.

You will be notified in writing of Our determination of any Evidence of Insurability submission

Change in Family Status:

What constitutes a Change in Family Status?

A Change in Family Status occurs when:

1) You get married or You execute a domestic partner affidavit;
2) You and Your spouse divorce or You terminate a domestic partnership;
3) Your child is born, or You adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;

5) Your child is no longer financially dependent on You or dies;
6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance; or a change in Your spouse's employment with the consequence that such spouse becomes eligible for other group insurance coverage;
7) You have a change in classification from part-time to full-time or from full-time to part-time;
8) Your spouse takes an unpaid leave of absence from the employer; or
9) Your dependent is no longer eligible.

PERIOD OF COVERAGE

Effective Date:

When does my coverage start?

Non-Contributory Coverage will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) The date You become eligible if You enroll on or before that date;
2) The January 1st following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) The date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:

1) The date You become eligible; or
2) The date We approve Your Evidence of Insurability or January 1st if you enroll during an annual enrollment period.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date:

When will my effective date for coverage or a change in my coverage be deferred?

If, on the date You are to become covered:

1) Under The Policy;
2) For increased benefits; or
3) For a new benefit;

You are not Actively at Work due to a physical or mental condition; such coverage will not start until the date You are Actively at Work.

Continuity from a Prior Policy:

Is there continuity of coverage from a Prior Policy?

Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance:

1) You had under the Prior Policy; or
2) Shown in the Schedule of Insurance;

reduced by any coverage amount:

1) That is in force, paid or payable under the Prior Policy; or
2) That would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

1) The last day of a period of 12 consecutive months after the Policy Effective Date;
2) The date Your insurance terminates for any reason shown under the Termination provision;
3) The last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) The date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Dependent Effective Date:

When does Dependent coverage start?

Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) The date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) The January 1st following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) The date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:

1) The date You become eligible for Dependent coverage; or
2) The date We approve Your Dependents' Evidence of Insurability.

In no event will Dependent coverage become effective before You become eligible.

Dependent Deferred Effective Date:

When will the effective date for Dependent coverage or a change in coverage be deferred?

If, on the date Your Dependent, other than a newborn, is to become covered:

1) Under The Policy;
2) For increased benefits; or
3) For a new benefit; and

he or she is:

1) Confined in a hospital; or
2) Confined Elsewhere;

such coverage will not start until he or she:

1) Is discharged from the hospital; or
2) Is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Child(ren).

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy:

Is there continuity of coverage from a Prior Policy for my Dependents?

If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the amount of life insurance:

1) Your Dependents had under the Prior Policy; or
2) Shown in the Schedule of Insurance;

reduced by any coverage amount:

1) That is in force, paid or payable under the Prior Policy; or
2) That would have been so payable under the Prior Policy had timely election been made.

Change in Coverage:

When may I change my coverage or coverage for my Dependents?

After Your initial enrollment You may increase or decrease coverage for You or Your Dependents, or add a new Dependent to Your existing Dependent coverage:

1) During any Annual Enrollment Period designated by the Policyholder; or
2) Within 31 days of the date of a Change in Family Status.

Effective Date for Changes in Coverage:

When will changes in coverage become effective?

Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

1) The date of the change;
2) The date requirements of the Deferred Effective Date provision are met;
3) The date Evidence of Insurability is approved, if required; or
4) The January 1st following the last day of the Annual Enrollment Period, except for an increase as a result of a Change in Family Status.

Increase in Amount of Life Insurance:

If I request an increase in the Amount of Life Insurance for myself, must I provide Evidence of Insurability?

If You are:

1) Already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must provide Evidence of Insurability for an increase of more than one level; or
2) Not already enrolled for an Amount of Supplemental Life Insurance under The Policy, You must provide Evidence of Insurability for an amount of Supplemental Life Insurance coverage greater than one level; including an initial amount.

If Your Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

Termination:

When will my coverage end?

Your coverage will end on the earliest of the following:

1) The date The Policy terminates;
2) The date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
3) The date the premium payment is due but not paid;
4) The date Your Employer terminates Your employment; or
5) The date You are no longer Actively at Work;

unless continued in accordance with any one of the Continuation Provisions.

Dependent Termination:

When does coverage for my Dependent end?

Coverage for Your Dependent will end on the earliest to occur of:

1) The date Your coverage ends;
2) The date the required premium is due but not paid;
3) The date You are no longer eligible for Dependent coverage;
4) The date We or the Employer terminate Dependent coverage; or
5) The date the Dependent no longer meets the definition of Dependent;

unless continued in accordance with the Continuation Provisions.

Continuation Provisions:

Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

1) Is subject to any reductions in The Policy;
2) Is subject to payment of premium;
3) May be continued up to the maximum time shown in the provisions; and
4) Terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The Continuation Provisions shown below may not be applied consecutively. The maximum amount of time covered under the continuation provision from the start of your continuous leave would be 60 months.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged

Leave of Absence: If You are on an approved leave of absence, other than Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for up to 60 months from the start date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 63 months from the start date leave of absence commenced. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Labor Dispute: If You are not Actively at Work as the result of a labor dispute, all of Your coverages (including Dependent Life coverage) may be continued during such dispute for a period not exceeding 6 months from the start date the leave of absence commenced. If the labor dispute ends, this continuation will cease immediately.

Severance: If Your employment terminates and continuation of life insurance is available to You and Your Dependents in a severance plan sponsored by the Employer, all of Your coverage (including Dependent Life coverage) may be continued. Your coverage will continue until the earliest of:

1) the date The Policy terminates;
2) the date You become covered under another group life insurance policy;
3) the end of the month coincident with or next following the date specified in Your severance plan; or
4) for up to 18 month(s) from the date Your employment terminated.

Coverage for Your Dependents will continue until the earliest of:

1) the date Your Dependents no longer meet the definition of Dependents;
2) the date We or Your Employer terminate Dependent coverage; or
3) the date Your coverage terminates.

Continuation for Dependent Child(ren) with Disabilities:

Will coverage for Dependent Child(ren) with disabilities be continued?

If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

1) Age 26 or older; and
2) Disabled; and
3) Primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:

1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
2) Such Dependent Child(ren) must have become disabled before attaining age 26.

Coverage under The Policy will continue as long as:

1) You remain insured;
2) The child continues to meet the required conditions; and
3) Any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Child(ren) will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

BENEFITS

Life Insurance Benefit:

When is the Life Insurance Benefit payable?

If You or Your Dependents die while covered under The Policy, We will pay the deceased person’s Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Accelerated Benefit:

What is the benefit?

In the event that You or Your Dependent are diagnosed as Terminally Ill while the Terminally Ill person is:

1) Covered under The Policy for an Amount of Life Insurance of at least $10,000; and

2) Under age 80;

We will pay the Accelerated Benefit in a lump sum amount as shown below, provided We receive proof of such Terminal Illness.

The Accelerated Benefit will not be available to You unless You have been Actively at Work under The Policy.

You must request in writing that a portion of the Terminally Ill person's Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit. In addition, Your remaining Amount of Life Insurance will be subject to any reductions in The Policy and will not increase once an Accelerated Benefit has been paid. Any premium required will be based on the amount of Your Life Insurance remaining after the Accelerated Benefit is paid under this benefit.

You may request a minimum Accelerated Benefit amount of $3,000, and a maximum of $500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of the Terminally Ill person's Amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $100,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from $3,000 to $80,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $3,000 now, You cannot request the additional $77,000 in the future.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or

2) If a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your or Your Dependent's Amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means that an individual has a medical condition which a Physician has certified is reasonably expected to result in death within 24 months or less after the date of certification.

Proof of Terminal Illness and Examinations:

Must proof of Terminal Illness be submitted?

We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You or Your Dependents do not submit proof of Terminal Illness satisfactory to Us, or if You or Your Dependents refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

Disputed Diagnosis:

What happens if a dispute occurs over whether I am Terminally Ill, or my Dependent is Terminally Ill?

If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician's opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State

of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other or may divide the costs equally or otherwise.

Conversion Right:

If coverage under The Policy ends, do I have a right to convert?

If Life Insurance coverage or any portion of it under The Policy ends for any reason, except nonpayment of premium, You and Your Dependents have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered under The Policy.

If coverage under The Policy ends because:

1) The Policy is terminated; or,
2) Coverage for an Eligible Class is terminated;

then You or Your Dependent must have been insured under The Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

1) $10,000; or
2) The Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, except nonpayment of premium, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right

Conversion:

How do I convert my coverage or my Dependents' coverage?

To convert Your coverage or coverage for Your Dependents, You must:

1) Complete a Notice of Conversion Right form; and
2) Have Your Employer sign the form.

The Insurer must receive this within:

1) 31 days after Life Insurance terminates; or
2) 15 days from the date Your Employer signs the form;

whichever is later. However, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

1) Complete and return the request form in the proposal; and
2) Pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You or Your Dependents under the Conversion Right:

1) Will be effective as of the 32nd day after the date coverage ends; and
2) Will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions:

What are the Conversion Policy provisions?

The Conversion Policy will:

1) Be issued on any one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and

2) Base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

1) The same terms and conditions of coverage as The Policy;

2) Any benefit other than the Life Insurance Benefit; and

3) Term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:

1) Under a certificate of insurance issued in accordance with the Portability provision; or

2) In accordance with the Continuation Provisions;

until such coverage ends.

Death within the Conversion Period:

What if I or my Dependents die before coverage is converted?

We will pay the deceased person's Amount of Life Insurance You would have had the right to apply for under this provision if:

1) Coverage under The Policy terminates; and

2) You or Your Dependent die within 31 days of the date coverage terminates; and

3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Portability Benefits:

What is Portability?

Portability is a provision which allows You and Your Dependents to continue coverage under a group Portability policy when coverage would otherwise end due to certain Qualifying Events.

Qualifying Events:

What are Qualifying Events?

Qualifying Events for You are:

1) Your employment terminates for any reason prior to Age 75; or

2) Your membership in an Eligible Class under The Policy ends;

provided the Qualifying Event occurs prior to Age 75.

Qualifying Events for Your Dependents are:

1) Your employment terminates, for any reason prior to Age 75;

2) Your death;

3) Your membership in a class eligible for Dependent coverage ends; or

4) He or she no longer meets the definition of Dependent, however, a Dependent Child(ren) who reaches the limiting age under The Policy is not eligible for Portability;

provided the Qualifying Event occurs prior to Normal Retirement Age.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse must elect to continue coverage due to your own Qualifying Event.

Electing Portability:

How do I elect Portability?

You may elect Portability for Your coverage after Your Basic and Supplemental Life Insurance coverage ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your Dependent coverage ends due to a Qualifying Event. The Policy must still be in force in order for Portability to be available.

To elect Portability for You or Your Dependents, You must:

1) Complete and have Your Employer sign a Portability application; and

2) Submit the application to Us, with the required premium.

This must be received within:

1) 31 days after Life Insurance terminates; or

2) 15 days from the date Your Employer signs the application;

whichever is later. However, Portability requests will not be accepted if they are received more than 91 days after Life Insurance terminates.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

1) Issued without Evidence of Insurability;

2) Issued on one of the forms then being issued by Us for Portability purposes; and

3) Effective on the day following the date Your or Your Dependent's coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Limitations:

What limitations apply to this benefit?

You may elect to continue 50%, 75%, or 100% of the Amount of Life Insurance which is ending for You or Your Dependent. This amount will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. However, the Amount of Life Insurance that may be continued will not exceed:

1) $1,000,000 for You;

2) $50,000 for Your Spouse; or

3) $10,000 for Your Dependent Child(ren).

If You elect to continue 50% or 75% now, You may not continue any portion of the remaining amount under this Portability provision at a later date. In no event will You or Your Dependents be able to continue an Amount of Life Insurance which is less than $5,000.

Portability is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered.

In addition, Portability is not available if You or Your Dependents are entering active military service.

Effect of Portability on Other Provisions:

How does Portability affect other Provisions?

Portability is not available for any Amount of Life Insurance which was, or is being, continued in accordance with the:

1) Conversion Right; or

2) Continuation provisions;

under The Policy. However, if:

1) You elect to continue only a portion of terminated coverage under this Portability Benefit; or

2) the Amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

GENERAL PROVISIONS

Notice of Claim:

When should I notify the Company of a claim?

You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after the date of death.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address, and the Policy Number.

Claim Forms:

Are special forms required to file a claim?

We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss:

What is Proof of Loss?

Proof of Loss may include, but is not limited to, the following:

1) A completed claim form;

2) A certified copy of the death certificate (if applicable);

3) Your Enrollment form;

4) Your Beneficiary Designation (if applicable);

5) Documentation of:

   d) The date Your disability began;

   e) The cause of Your disability; and

   f) The prognosis of Your disability;

6) Any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;

7) The names and addresses of all:

   g) Physicians or other qualified medical professionals You have consulted;

   h) Hospitals or other medical facilities in which You have been treated; and

   i) Pharmacies which have filled Your prescriptions within the past three years;

8) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or

9) Any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss:

When must Proof of Loss be given?

Written Proof of Loss should be sent to Us or Our representative within 365 day(s) after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

1) It was not reasonably possible to give proof within the required time; and
2) Proof is given as soon as reasonably possible; but
3) Not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy:

Can We have a claimant examined or request an autopsy?

While a claim is pending, We have the right at Our expense:

1) To have the person who has a loss examined by a Physician when and as often as We reasonably require; and
2) To have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment:

When are benefit payments issued?

When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Benefits may be subject to interest payments as required by applicable law.

Claims to be Paid:

To whom will benefits for my claim be paid?

Life Insurance Benefits will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1) All to Your surviving spouse;
2) If Your spouse does not survive You, in equal shares to Your surviving children; or
3) If no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

1) $200 at Your death; and
2) Monthly installments of not more than $200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Life Insurance Benefit at Your Dependent's death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving spouse or the executor or administrator of Your estate.

If benefits are payable and meet Our guidelines, then You, or your Beneficiary, may elect to receive benefits in a lump sum payment or may elect to receive benefits through a draft book account. The draft book account will be owned by:

1) You, if living; or

2) Your beneficiary, in the event of Your death.

However, an account will not be established for:

1) A benefit payable to Your estate; or

2) An amount that is less than $10,000.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:

1) Your estate;

2) A person who is a minor; or

3) A person who is not legally competent,

then We may pay up to $1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Beneficiary Designation:

How do I designate or change my beneficiary?

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a power of attorney.

Claim Denial:

What notification will my beneficiary or I receive if a claim is denied?

If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

1) Give the specific reason(s) for the denial;

2) Make specific reference to the provisions upon which the denial is based;

3) Provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and

4) Provide an explanation of the review procedure.

Claim Appeal:

What recourse do my beneficiary, or I have if a claim is denied?

On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

1) Must request a review upon written application within:

   j) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or

   k) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and

2) May request copies of all documents, records, and other information relevant to the claim; and

3) May submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Eligibility Determination:

How will We determine Your or Your Dependent's eligibility for benefits?

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your Dependent's eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:

1) Obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim; Consider and interpret The Policy and all information obtained by Us and submitted by You or Your beneficiaries that relates to Your or Your beneficiaries' claim for benefits and make Our determination of Your or Your Dependent's eligibility for benefits based on that information and in accordance with The Policy and applicable law;
2) If We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
3) If We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal**. If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

Incontestability:

When can the Life Insurance Benefit of The Policy be contested?

Except for non-payment of premiums, Your or Your Dependent's Life Insurance Benefit cannot be contested after two years from its effective date.

In the absence of fraud, no statement made by You or Your Spouse relating to Your or Your Spouse's insurability will be used to contest Your insurance for which the statement was made after Your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You and Your Spouse.

No statement made relating to Your Dependents being insurable will be used to contest their insurance for which the statement was made after their insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You or Your representative.

All statements made by the Policyholder, the Employer or You or Your Spouse under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

Assignment:

Are there any rights of assignment?

You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:

1) The right to make any contributions required to keep the insurance in force;
2) The right to convert; and
3) The right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

1) It is duly executed; and

2) A copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) For the validity or effect of any assignment; or

2) To provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions:

When can legal action be taken against Us?

Legal action cannot be taken against Us:

1) Sooner than 60 days after the date written Proof of Loss is furnished; or

2) More than 6 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation:

How does The Policy affect Workers' Compensation coverage?

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Insurance Fraud:

How does the Company deal with fraud?

Insurance fraud occurs when You, Your Dependents and/or the Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your Dependents and/or the Employer commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your Dependents and/or the Employer perpetrate insurance fraud.

Misstatements:

What happens if facts are misstated?

If material facts about You or Your Dependents were not stated accurately:

1) The premium may be adjusted; and

2) The true facts will be used to determine if, and for what amount, coverage should have been in force.

DEFINITIONS

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

1) In the usual way; and

2) For Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day, paid time off day, personal day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Commissions means the total of monetary commissions You received from the Employer over:

1) The twelve-month period immediately prior to the date You were last Actively at Work; or

2) The total period of time You worked for the Employer, if less than the above period.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means Your children, stepchildren, legally adopted children, or any other children related to You by blood or marriage or domestic partnership provided such children are:

1) From live birth but not yet 26 years; or

2) Age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, of such children's disability.

Dependents means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States of America, its territories and protectorates.

Earnings means Your regular annual rate of pay, including Commissions, but not bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day You were Actively at Work.

However, if You are an hourly paid Active Employee, Earnings means the product of:

1) The average number of hours You worked per year, not including overtime, over the most recent 1-year period immediately prior to the last day You were Actively at Work, multiplied by:

2) Your hourly wage in effect on the date immediately prior to the last day You were Actively at Work.

Employer means the Policyholder.

Guaranteed Issue Amount means the Amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Normal Retirement Age means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Physician means a person who is:

1) A Doctor of Medicine, Osteopathy, Psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;

2) Licensed to practice in the jurisdiction where care is being given;

3) Practicing within the scope of that license; and

4) Not You or Related to You by blood or marriage.

Prior Policy means the group life insurance policy carried by the Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Related means Your Spouse, or someone in a similar relationship in law to You, or other adult living with You, or Your sibling, parent, stepparent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Spouse means Your spouse who:

1) Is not legally separated or divorced from You; and
2) Is not in active full-time military service.

Spouse will include Your domestic partner provided You:

1) Have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
2) Have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Us, or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this Certificate of Insurance is issued.

NONINSURANCE BENEFITS AND SERVICES

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

Benefits and Services

In addition to the Insurance coverage, the Policyholder may offer noninsurance benefits and services to Eligible Persons based on Policyholder plan design. Eligible Persons should contact the Policyholder for more information on the services available on their plan.

Eligible Persons can obtain a description and contact information for noninsurance benefits and services by visiting **www.thehartfordatwork.com**.

The following noninsurance benefits and services may be made available:

- **Will Preparation Services.** These services provide access to an online tool to help You create a customized will with the help of licensed attorneys, if needed.
- **Financial and Estate Planning Services.** Estate Planning Services provide support to You or Your beneficiaries prior to—or immediately following—the loss of a loved one. Services include access to funeral planning tools and resources to answer questions as well as access to beneficiary support resources who provide emotional, legal or financial guidance during a difficult time. Funeral planning tools and resources do not constitute an insurance funded prearrangement contract as described in the Revised Code of Washington (RCW)18.39.255. Financial Planning Services include identity theft services to help You or Your immediate family members with the financial impacts should the theft occur. They also include travel related services to help You or Your immediate family members reduce financial expenses associated with traveling while providing emergency medical assistance should the unexpected happen.

The noninsurance benefits and services provided are offered by third party administrators or vendors. While The Hartford has arranged these benefits and services, the third-party providers are liable to the Eligible Persons for the provision of such benefits and services. The Hartford is not responsible for the provision of benefits and services nor is it liable for the failure of the provision of the same. Further, The Hartford is not liable to Eligible Persons for the negligent provisions of such benefits and services by the third-party providers. Note that The Hartford in its sole discretion may change vendors or may terminate any noninsurance benefit or service. The Eligible Persons will be given 60 days' notice of such termination, unless the termination is due to circumstances beyond The Hartford's control, such as vendor terminating its services.

Signed for Hartford Life and Accident Insurance Company

Kevin Barnett, Secretary **Jonathan Bennett, President**

Form PA-9432 (HLA) (WA) (Rev-2)

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

STATE NOTICES

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at **https://www.thehartford.com/**. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1) If notice of Your **Conversion Right** is not received by You on the date Your or Your Dependent's coverage terminates, You have 15 days from the date You receive the notice.
2) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3) The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

Arizona:

1) **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1) **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72201-1904

California:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, does not apply to you. The following requirement applies to you:

Eligibility Determination:

How will We determine Your or Your Dependent's eligibility for benefits?

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your Dependent's eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:

a) Obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;

b) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;

c) If We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;

d) If We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled Claim Denial.

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal**. If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

2) For Your Questions and Complaints:

State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833
Web Address: www.insurance.ca.gov

Colorado:

1) The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

2) The **Dependent Child(ren)** definition will always include children related to You by civil union.

3) The **Spouse** definition will always include civil unions.

4) Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.

Florida:

1) **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

2) NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.

Georgia:

1) **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1) For Your Questions and Complaints:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043
Toll Free: 1-800-721-3272
Web Address: www.DOI.Idaho.gov

Illinois:

1) For Your Questions and Complaints:

   Illinois Department of Insurance
   Consumer Services Station
   Springfield, Illinois 62767
   Consumer Assistance: 1(866) 445-5364
   Officer of Consumer Health Insurance: 1(877) 527-9431

2) In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 et seq. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at www.insurance.illinois.gov.

Indiana:

1) For Your Questions and Complaints:

   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1 (317) 232-2395

Louisiana:

1) The age limit stated in the **Continuation for Dependent Child(ren)** with Disabilities provision is increased to 21, if less than 21.

2) The following requirement applies to you:

Reinstatement after Military Service:

Can coverage be reinstated after return from active military service?

If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

The reinstated coverage will:

a) Be the same coverage amounts in force on the date coverage ended;

b) Not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and

c) Be subject to all the terms and provisions of The Policy.

Maine:

1) **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third-Party Notice Request Form shall be mailed or personally delivered to the insured.

Massachusetts:

1) The definition of **Terminal Illness** or **Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.

2) NOTICE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (**www.mahealthconnector.org**).

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at **www.mass.gov/doi**.

Michigan:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1) You or Your Dependents must be on a documented military leave of absence in order to qualify for the Military Leave of Absence continuation shown in the **Continuation Provisions**.

2) If there are 25 or more residents of Minnesota who are covered under The Policy, or there are fewer than 25 residents and those residents constitute 25% or more of the total number of people covered under The Policy, the Lay Off continuation shown in the **Continuation Provisions** shall not apply to you. The following requirement applies to you:

Minnesota Coverage Continuation: If You are voluntarily or involuntarily terminated or Laid Off by the Employer, You may elect to continue Your Life Insurance coverage (including Dependent Life coverage) by making premium payments to the Employer for the cost of continued coverage. Continued coverage will take effect on the date Your coverage would otherwise have ended and must be elected within 60 days from:

a) The date Your coverage would otherwise terminate; or

b) The date You receive a written notice of Your right to continue coverage from the Employer;

whichever is later.

The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:

a) Your right to continue coverage;

b) The amount of premium; and

c) How, where and by when payment must be made.

Upon request, the Employer will provide You Our written verification of the cost of coverage.

Coverage will be continued until the earliest of:

a) The date You are covered under another group policy;

b) The date the required premium is due but not paid; or

c) The last day of the 18th month following the date of termination or Lay Off.

Upon the termination of continued coverage, You may:

a) Exercise Your Conversion Right; or

b) Continue coverage under a group Portability policy; and

c) Qualify for Retiree coverage.

Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.

3) If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

In the event:

a) You are required by law to accelerate benefits to meet the claims of creditors; or

b) If a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit

4) If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, You are not required to be insured under The Policy for a specified period of time in order to exercise the **Conversion Right**.

Missouri:

1) The period in which You must remain Disabled to qualify for **Waiver of Premium** cannot exceed 180 days.

2) If Waiver of Premium is approved and You have completed the elimination period, We will retroactively refund to You, or to Your estate if You have died, any premiums paid during the period You have been continuously Disabled.

3) The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Montana:

1) The time period in which You are required to be insured under The Policy in order to exercise the **Conversion Right** cannot exceed 3 years.

2) If You are eligible to receive the **Felonious Assault Benefit**, We will not exclude for losses that result from a Felonious Assault committed by a member of Your family or a member of the household in which You live.

3) **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.

New Hampshire:

1) Your Spouse may be eligible to continue his or her Life Insurance coverage in the event of divorce or separation as shown in the **Spouse Continuation** below:

   Spouse Continuation:

   Can coverage for my Spouse be continued in the event of divorce or separation?

   If:

   a) You are a resident of New Hampshire;

   b) You get a divorce or legal separation from a Spouse that is covered under The Policy; and

   c) The final decree of divorce or legal separation does not expressly prohibit it;

   Your former Spouse may continue his or her coverage.

   We must receive Your Spouse's written request and the required premium to continue his or her coverage within 30 days of the final decree of divorce or legal separation.

   Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your former Spouse's coverage will not continue beyond the earliest of:

   a) The 3-year anniversary of the final decree of divorce or legal separation;

   b) The remarriage of the former Spouse;

   c) Your death;

   d) An earlier time as provided by the final decree of divorce or legal separation; or

   e) A date the coverage would otherwise have ended under the Dependent Termination Provision.

New Mexico:

1) For Your Questions and Complaints:

   Office of Superintendent of Insurance
   Consumer Assistance Bureau
   P.O. Box 1689
   Santa Fe, NM 87504-1689
   1(855) 427-5674

New York:

1) If the definition of **Spouse** requires the completion of a domestic partner affidavit, the requirement applies to you:

   The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:

   a) You are both are legally and mentally competent to consent to contract in the state in which you reside;

   b) You are not related by blood in a manner that would bar marriage under laws of the state in which you reside;

   c) You have been living together on a continuous basis prior to the date of the application;

   d) Neither of you have been registered as a member of another domestic partnership within the last six months; and

   e) You provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

   The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

   a) A joint bank account;

   b) A joint credit card or charge card;

c) Joint obligation on a loan;

d) Status as an authorized signatory on the partner's bank account, credit card or charge card;

e) Joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;

f) Listing of both partners as tenants on the lease of the shared residence;

g) Shared rental payments of residence (need not be shared 50/50)

h) Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;

i) A common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);

j) Shared household budget for purposes of receiving government benefits;

k) Status of one as representative payee for the other's government benefits;

l) Joint responsibility for child care (e.g., school documents, guardianship);

m) Shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);

n) Execution of wills naming each other as executor and/or beneficiary;

o) Designation as beneficiary under the other's life insurance policy;

p) Designation as beneficiary under the other's retirement benefits account;

q) Mutual grant of durable power of attorney;

r) Mutual grant of authority to make health care decisions (e.g., health care power of attorney);

s) Affidavit by creditor or other individual able to testify to partners' financial interdependence;

t) Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1) **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD-PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:

   a) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND

   b) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

North Dakota:

1) The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Ohio:

1) Any references to the **Accelerated Benefit** shall be changed to the **Accelerated Death Benefit**.

Oregon:

1) The **Spouse** definition will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2) The **Dependent Child(ren)** definition will include children related to You by domestic partnership.
3) The following Jury Duty continuation applies for Employers with 10 or more employees:

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

   a) Elected to have Your coverage continued; and

   b) Provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1) The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to $2,000, if greater than $2,000.
2) If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.
3) If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.
4) If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a period of up to 12 months from the date The Policy terminated, or Your Employer ceased to be a Participating Employer, as long as premiums are paid when due. Coverage during this period will be subject to the other terms and conditions of the **Disability Extension Ceases** provision. When this extension period is exhausted, You may be eligible to exercise the **Conversion Right** for You and Your Dependent's coverage. **Portability Benefits** will not be available

South Dakota:

1) The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

Texas:

1) The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable

2) NOTICE

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call:
Customer Service at 860-547-5000
Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford

Email: GBD.Customerservice@hartfordlife.com

Mail:
The Hartford
Group Benefits Division
P.O. Box 2999
Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question:
1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail:
MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000
Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford
Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal:
The Hartford

Group Benefits Division
P.O. Box 2999
Hartford, CT 06104

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al:
1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal:
MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

Utah:

1) We will send **Claim Forms** within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.
2) If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.
3) When We determine that benefits are payable, We will make **Claim Payments** within no more than 45 days after Proof of Loss is received.
4) Any reference to fraud within the **Incontestability** provision does not apply to You.
5) A Sickness or Injury continuation of at least 6 months must be included in the **Continuation Provisions**.

Vermont:

1) The following requirement applies:

   Purpose: This requirement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this requirement, the civil union must have been established in the state of Vermont according to Vermont law.

   General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

   a) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.

   b) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.

   c) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.

   d) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

   e) "Child or covered child" means a child (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

Cautionary Disclosure: THIS NOTICE IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE NOTICE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS NOTICE. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

2) Interest on a **Claim Payment** is payable from the date of death until the date payment is made at an interest rate of 6% annually or Our corporate interest rate, whichever is greater.

Virginia:

1) For Your Questions and Complaints:

   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23209
   1(804) 371-9741 (inside Virginia)
   1(800) 552-7945 (outside Virginia)

Washington:

1) The following **Disputed Diagnosis** requirement applies to You:

   Disputed Diagnosis:

   What happens if a dispute occurs over whether I am Terminally Ill, or my Dependent is Terminally Ill?

   If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician’s opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other or may divide the costs equally or otherwise.

2) A Labor Dispute continuation of at least 6 months must be included in the **Continuations Provisions**.

3) The **Dependent Child(ren)** definition will always include children related to You by domestic partnership.

4) The definition of **Spouse** will always include domestic partners.

5) The provision titled **Suicide** does not apply to you.

Wisconsin:

1) For Your Questions and Complaints:

   To request a Complaint Form:
   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
   Madison, WI 53707-7873
   1(800) 236-8517 (outside of Madison)
   1(608) 266-0103 (in Madison)

ERISA INFORMATION

THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

1) Plan Name

T-MOBILE USA, INC. EMPLOYEE BENEFIT PLAN.

2) Plan Number

LIFE – 506

3) Employer / Plan Sponsor

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

4) Employer Identification Number

91-1983600

5) Type of Plan

Welfare Benefit Plan providing Group Basic Term Life, Supplemental Dependent Life, Supplemental Term Life.

6) Plan Administrator

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

7) Agent for Service of Legal Process

For the Plan:

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

8) Sources of Contributions (Life)

Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out-of-pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan and may be used to reduce what the Employer pays for basic coverage.

9) Type of Administration

The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

10) The Plan and its records are kept on a Policy year basis.

11) Labor Organizations

None

12) Names and Addresses of Trustees

None

13) Plan Amendment Procedure

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF 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), as amended. ERISA provides that all Plan participants shall be entitled to:

1) Receive Information About Your Plan and Benefits

a) 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.

b) 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.

c) 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.

2) 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.

3) 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

4) 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 (formerly known as the Pension and Welfare Benefits 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.

Claim Procedures

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits:

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. 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 the Insurance Company receives your response to our request. If the Insurance Company 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 include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you

and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) 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 medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) 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 for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits:

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

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

The Insurance Company's review on appeal 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.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45-day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it 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 Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit 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 Insurance Company 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 benefit decision, nor a subordinate of such individual. If the Insurance

Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) 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 medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability:

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits:

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits:

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and

2. You may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal 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.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and 36 other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet is Insured by the

Hartford Life and Accident Insurance Company
Hartford, Connecticut
Member of The Hartford Insurance Group

Accidental Death and Dismemberment

Certificate of Insurance
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut

Policyholder: T-Mobile USA, Inc.

Policy Number: ADD-S07649

Policy Effective Date: June 1, 2013

Certificate Effective Date: January 1, 2020

We have issued a policy to the Policyholder. Our name, the Policyholder name and the Policy Number are shown above. The provisions of the policy which are important to you are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to you earlier for the policy. The policy alone is the only contract under which payment will be made. Any difference between the policy and this Certificate will be settled according to the provisions of the policy.

Lisa Levin, Secretary **Jonathan Bennett, President**

Form PA-5427 A2 (-S07649)

Printed in U.S.A.

SCHEDULE

Cost of Coverage:

Non-Contributory Coverage: Basic Accidental Death and Dismemberment Insurance

Contributory Coverage: Supplemental Accidental Death and Dismemberment Insurance

Eligible Persons

Class 1: All Full-time and Part-time Active Employees of the Policyholder.

Eligibility Waiting Period for Coverage

Basic—None

Supplemental—First of the month following 30 days

Employee Definitions

Full-time Employee means a person who:

1) Is regularly employed by the Policyholder in the usual course of their business; and
2) Works at least 30 hours per work week.

Part-time Employee means a person who:

1) Is regularly employed by the Policyholder in the usual course of their business; and
2) Works at least 20 hours per work week.

Basic Principal Sum
1.5 times Your annual Earnings, subject to a maximum of $1,000,000 rounded to the next higher $1,000 if not already a multiple of $1,000.

Supplemental Principal Sum
1, 2, 3, 4, 5, 6, 7 or 8 times Your annual Earnings, subject to a maximum of $2,000,000 rounded to the next higher $1,000 if not already a multiple of $1,000.

Earnings

Earnings means Your regular annual rate of pay, including Commissions, but not bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day You were Actively at work.

However, if You are an hourly paid Active Employee, Earnings means the product of:

1) The average number of hours You worked per year, not including overtime, over the most recent 1-year period immediately prior to the last day You were Actively at Work, multiplied by:
2) Your hourly wage in effect on the date immediately prior to the last day You were Actively at Work.

Commissions

Commissions means the total of monetary commissions You received from the Employer over:

1) The twelve-month period immediately prior to the date You were last Actively at Work; or
2) The total period of time You worked for the Employer, if less than the above period.

Eligible Dependents

Eligible Person's Spouse and Child(ren)

Supplemental Principal Sum For Each Insured Person's Eligible Dependents

The Principal Sum applicable to each person covered under this policy as an Insured Person's Dependent is calculated by applying the percent, determined below, to the Insured Person's Principal Sum.

	Percent Applicable to:	
Insured Person with Covered:*	Spouse	Each Child
Spouse, but no covered Child	60%	0%
Spouse & Child(ren)	50%	25%
Child(ren), but no covered Spouse	0%	25%

*As determined on the date of accident

The Principal Sum cannot exceed the lesser of the amount calculated above or as follows:

Spouse Only:	$900,000
Child Only:	$100,000
Spouse & Child:	$750,000 / $100,000

Policy Age Limit

None

Seat Belt and Air Bag Coverage

Seat Belt Benefit Amount: 10%
Maximum Amount: $10,000

Air Bag Benefit Amount: 100%
Maximum Amount: $5,000

Spouse Education Benefit

Maximum Amount: $25,000
Percentage of Principal Sum: 20%
Minimum Amount: $500

Child Education Benefit

Maximum Amount: $20,000
Percentage of Principal Sum: 10%
Minimum Amount: $2,500

Conversion Privilege Benefit (Insured Person Only)

Conversion Limit: $250,000

Extended Felonious Assault Benefit

Percentage of Principal Sum: 50%
Maximum Amount: $25,000

Repatriation Benefit (Insured Person Only)

Percentage of Principal Sum: 10%
Maximum Amount: $5,000

Rehab Benefit

Percentage of Principal Sum: 10%
Maximum Amount: $10,000

Common Carrier Benefit

Common Carrier Limit: $500,000

Day Care Benefit (Insured Person Only)

Maximum Amount: $12,500
Percentage of Principal Sum: 20%
Minimum Amount: $500

Coma Benefit (Insured Person only)

Waiting Period: 30 days

Traumatic Brain Injury

Waiting Period: 30 days
Percentage: 100%

Emergency Evacuation

Maximum Amount: $250,000

Medical / Dental

Percentage of principal Sum: 5%

Maximum Amount: $5,000

Dependent Child Dismemberment

Maximum Amount: $100,000

DEFINITIONS

Active Full-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. You must work at least the number of hours in the Employer's normal work week. This must be at least 30 hours per week for full-time and 20 hours per week for part-time. You will be considered actively at work with Your Employer on a day which is one of the Employer's scheduled work days if You are performing, in the usual way, all of the regular duties of Your job on a regular basis that day. You will also be considered actively at work on a paid vacation day or a day which is not one of the Employer's scheduled work days only if You were actively at work on the preceding scheduled work day.

Employer means the Policyholder named in the Schedule of Insurance.

We, us or **our** means the insurance company named on the face page.

You, your or **Insured Person** means an Eligible Person while he or she is covered under the policy.

Actively-at-Work means a person who is performing all the regular duties of his or her occupation on a Full-time basis at his or her regular place of employment or while on a Business Trip.

Actively-at-Work does not include everyday travel to and from work.

Business Trip means a bona fide trip while on assignment at the direction of the Policyholder for the purpose of furthering the business of the Policyholder:

1) Which begins when a person leaves his or her residence or place of regular employment, whichever last occurs, for the purpose of beginning the trip;

2) Which ends when he or she returns to his or her residence or place of regular employment, whichever first occurs.

Injury means bodily injury resulting directly and independently of all other causes from an accident which occurs while you are:

1) Actively-at-Work; and

2) Covered under the policy.

Loss resulting from:

1) Sickness or disease, except a pus-forming infection which occurs through an accidental wound; or

2) Medical or surgical treatment of a sickness or disease;

Is not considered as resulting from Injury.

On, when used with reference to any conveyance (land, water or air), means in or on, boarding or alighting from the conveyance.

Civil or Public Aircraft means an aircraft which:

1) Has a current and valid Airworthiness Certificate;

2) Is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and

3) Is not operated by the militia or armed forces of any state, national government or international authority.

Airworthiness Certificate means:

1) The "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration; or

2) A foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Military Transport Aircraft means a transport aircraft operated by:

1) The United States Air Mobility Command (AMC); or

2) A national military air transport service of any country.

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Scheduled Aircraft means a Civil Aircraft operated by a scheduled airline which:

1) Is licensed by the FAA for the transportation of passengers for hire; and

2) Publishes its flight schedules and fares for regular passenger service.

Written Request means any form provided by us for the particular request.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date:

Each Eligible Person becomes an Insured Person for Basic Benefits on the later of:

1) The Policy Effective Date; or

2) The first day of the month on or next following the date he or she becomes eligible.

Each Eligible Person is eligible for Voluntary Benefits and who gives us a Written Request for those Benefits becomes covered for those Benefits on the later of:

1) The Policy Effective Date; or

2) The first day of the month on or next following the date we receive the request.

Termination:

Coverage of each person as an Insured Person terminates on the earlier of:

1) The date the policy is terminated; or

2) The Premium Due Date on or next following the date he or she:

   a) Ceases to be an Eligible Person, or

   b) Attains the Policy Age Limit, if any, shown in the Schedule.

An Insured Person's coverage for Voluntary Benefits terminates on the earlier of:

1) The date he or she requests that his or her Voluntary Benefits as an Insured Person be terminated;

2) The Premium Due Date on or next following the date he or she ceases to be eligible for Voluntary Benefits; or

3) The Premium Due Date on which he or she fails to pay any required premium for Voluntary Benefits.

Request For Change In Coverage:

If an Insured Person gives us a Written Request for a change in his or her coverage, and if he or she:

1) Is not eligible for the coverage requested, the change will not become effective;

2) Is eligible for the coverage requested, the change will become effective on the first of the month on or next following the date we receive the request.

DEPENDENTS PERIOD OF COVERAGE

Eligibility:

Eligible Dependents are defined in the Schedule. In any event, an Insured Person is not an Eligible Dependent.

Spouse

Spouse means the Eligible Person's spouse unless:

1) The Eligible Person and spouse are legally separated or divorced; or
2) The spouse has attained the Policy Age Limit, if any, shown in the Schedule.

The term "spouse" used in this policy will include, with respect to California residents only, an individual who is in a registered domestic partnership with the Eligible Person in accordance with California law. Reference to an Eligible Person's marriage or divorce shall include his or her registered domestic partnership or dissolution of his or her registered domestic partnership.

Child or Children

Child or Children means the Eligible Person's unmarried child, stepchild, legally adopted child, or foster child:

1) Who is less than age 26 and primarily dependent on the Insured Person for support and maintenance; or
2) Who is but less than age 26 who:
    a) Regularly attends an institution of learning; and
    b) Is primarily dependent on the Insured Person for support and maintenance.

Effective Date:

Each Eligible Dependent will become covered under the policy on the later of:

1) The date the Eligible Person becomes an Insured Person; or
2) The date the person qualifies as an Eligible Dependent.

Termination:

Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earliest of:

1) The date the Eligible Person ceases to be an Insured Person; or
2) The date he or she ceases to qualify as an Eligible Dependent.

Incapacitated Child

Coverage of a child who, on the date he or she reaches age 26, is:

1) Covered under the policy;
2) Mentally or physically incapable of earning his or her own living; and
3) Unmarried and primarily dependent on the Insured Person for support and maintenance;

will not terminate solely due to age. But the Insured Person must give us written notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:

1) The incapacity continues; and
2) The required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year.

EXCEPTIONS TO TERMINATION

Under what conditions can Your insurance be continued under the continuation provisions?

If You are absent from work as an Active Employee due to a labor dispute, all of Your coverage may be continued for up to 6 months from the start date the leave of absence commenced. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:

1) Is subject to any reductions in the Policy;
2) Is subject to payment of premium by the Employer; and
3) Terminates when the Policy terminates.

If You are on an approved leave of absence, other than military leave, all of Your coverage may be continued for up to 60 months from the start date the leave of absence commenced, or the first to occur of:

1) The date the Group Insurance Policy terminates;
2) The date premium is due for You but not paid by the Employer; or
3) The last day of the period for which You made any required premium contribution, if You fail to make any further required contribution.

If You enter active military service and are granted a military leave of absence in writing, all of Your coverage may be continued for up to 63 months from the start date the leave of absence commenced, or the first to occur of:

1) The date the Group Insurance Policy terminates;
2) The date premium is due for You but not paid by the Employer; or
3) The last day of the period for which You make any required premium contribution, if You fail to make any further required contribution.

If Your employment terminates and continuation of accidental death and dismemberment is available to You and Your Dependents in a severance plan sponsored by the Employer, all of Your coverage may be continued. Your coverage will continue until the earliest of:

1) The date The Policy terminates;
2) The date you become covered under another accidental death and dismemberment policy;
3) The end of the month coincident with or next following the date specified in Your severance plan; or
4) For up to18 months from the date Your employment terminated.:

Coverage for Your Dependents will continue until the earliest of 1) the date Your Dependents no longer meet the definition of Dependents; 2) the date We or Your Employer terminate Dependent coverage; or 3. the date Your coverage terminates.

In all other respects, the terms of Your insurance remains unchanged.

1) The leave terminated prior to the agreed upon date;
2) The Policy terminated;
3) You or the Policyholder fail to pay premium when due; or
4) The Policy no longer insures Your class.

In all other respects, the terms of Your insurance remain unchanged.

EXCLUSIONS

The policy does not cover any loss resulting from:

1) Intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2) War or act of war, whether declared or undeclared;
3) Injury sustained while full-time in the armed forces of any country or international authority;
4) Injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
5) Injury sustained while riding On any aircraft:
   a) As a pilot, crewmember or student pilot;
   b) As a flight instructor or examiner; or
   c) If it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization whose eligible persons are covered under the policy;
6) Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
7) Injury sustained while committing or attempting to commit a felony;
8) Injury sustained as a result of being legally intoxicated from the use of alcohol.

Coverage is limited to $50,000 for Employees who are pilots flying an aircraft that is not Corporate Owned or Leased

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If an Insured Person's injury results in any of the following losses within 365 days after the date of accident, we will pay the sum shown opposite the loss. We will not pay more than the Principal Sum for all losses due to the same accident. The amount of the Principal Sum is determined in the Schedule.

For Loss of:

Life ..... The Principal Sum

Both Hands or Both Feet or Sight of Both Eyes ..... The Principal Sum

One Hand and One Foot ..... The Principal Sum

Speech and Hearing ..... The Principal Sum

Either Hand or Foot and Sight of One Eye ..... The Principal Sum

Movement of Both Upper and Lower Limbs (Quadriplegia) ..... One Hundred and Fifty The Principal Sum

Movement of Both Lower Limbs (Paraplegia) ..... Three-Quarters The Principal Sum

Movement of Three Limbs (Triplegia) ..... Three-Quarters The Principal Sum

Movement of Both Upper and Lower Limbs of One Side of Body (Hemiplegia).. Sixty-Six and Two Thirds The Principal Sum

Either Hand or Foot ..... One-Half The Principal Sum

Sight of One Eye..... One-Half The Principal Sum

Speech or Hearing ..... One-Half The Principal Sum

Movement of One Limb (Uniplegia) ..... One-Half The Principal Sum

Thumb and Index Finger of Either Hand ..... One-Quarter The Principal Sum

Loss means with regard to:

1) Hands and feet, actual severance through or above wrist or ankle joints;
2) Sight, speech or hearing, entire and irrecoverable loss thereof;

3) Thumb and index finger, actual severance through or above the metacarpophalangeal joints;

4) Movement of limbs, complete and irreversible paralysis of such limbs.

If loss is sustained by an Insured Person while riding as a passenger on any Common Carrier, the amount of Principal Sum payable under the Accidental Death and Dismemberment Benefit will be doubled. However, in no event will the Principal Sum stated in the Schedule be increased by more than the Common Carrier Limit.

Common Carrier means a Conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

EXPOSURE

Exposure to the elements will be presumed to be injury if:

1) It results from the forced landing, stranding, sinking or wrecking of a conveyance in which the Insured Person was an occupant at the time of the accident; and

2) This policy would have covered injury resulting from the accident.

DISAPPEARANCE

An Insured Person will be presumed to have suffered loss of life if:

1) His or her body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance;

2) The disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and

3) This policy would have covered injury resulting from the accident.

SEAT BELT & AIR BAG BENEFIT

If Your Injury results in a covered Loss under the Accidental Death and Dismemberment Benefit while:

1) A passenger riding in; or

2) The licensed operator of;

   An Automobile, and at the time of the accident You were properly wearing a Seat Belt as verified on the police report, then the amount of the Principal Sum will be increased by a Percentage of the Principal Sum, up to a Maximum Amount.

If the above Seat Belt Benefit is payable, we will pay an additional Percentage of the Principal Sum, up to a Maximum Amount, as an Air Bag Benefit if:

1) You were positioned in a seat that was equipped with a factory-installed Air Bag;

2) You were properly strapped in the Seat Belt when the Air Bag inflated; and

3) The police report establishes that the Air Bag inflated properly upon impact.

Air Bag means an inflatable, supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

Automobile means a duly registered, four-wheeled, private passenger: car, pick-up truck, van, self-propelled motor home or sport utility vehicle which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications.

Exclusions: This Seat Belt and Air Bag Benefit does not cover any loss if You were:

1) Using any controlled substance, as defined in Title II of the Connecticut Comprehensive Drug Abuse Prevention and Control Act of 1970, unless prescribed by a physician; and

2) Operating the Automobile.

The Percentage of the Principal Sum, Minimum Amount and Maximum Amount for the Seat Belt and Air Bag Benefit are shown in the Schedule.

EDUCATION BENEFIT

If:

1) The Insured Person's Spouse and Eligible Child(ren) are covered under the policy; and

2) A Principal Sum is payable under the Accidental Death and Dismemberment Benefit because of the Insured Person's or Covered Spouse's death; we will pay an Education Benefit to each Student as provided below.

A Student is a person for whom we receive proof that he or she:

1) Is covered as the Insured Person's Eligible Dependent on the date of the Insured Person's or Covered Spouse's death; and

2) Is a full-time post-high school student in a school for higher learning on the date of the Insured Person's or Covered Spouse's death; or

3) Became a full-time post-high school student in a school for higher learning within 365 days after the Insured Person's or Covered Person's death and was a student in the 12th grade on the date of the Insured Person's or Covered Person's death.

He or she is not considered to be a Student after the first to occur of:

1) Our payment of the fourth Education Benefit to or on behalf of that person; or

2) The end of the 12th consecutive month during which we have not received proof that he or she is a Student.

If the Insured Person dies, the Education Benefit is an amount equal to the lesser of:

1) The Maximum Amount; or

2) The amount determined by applying the Percent to the amount of the Insured Person's Principal Sum.

If the Covered Spouse dies, the Education Benefit is an amount equal to the lesser of:

1) The Maximum Amount; or

2) The amount determined by applying the Percent to the amount of the Covered Spouse's Principal Sum.

We will pay the Education Benefit to any one Student during any one school year.

The Education Benefit is payable to each person:

1) On the date; and

2) For whom;

We have received proof that he or she is a Student.

If he or she is a minor, we will pay the benefit to the Student's legal representative.

If:

1) A Principal Sum is payable because of the Insured Person's and/or Covered Spouse's death; and

2) No Eligible Dependent qualifies as a Student;

We will pay the Minimum Amount in accordance with the Payment of Claims provision.

The amount of Principal Sum is determined in the Schedule.

The Maximum Amount, Percent and Minimum Amount are shown in the Schedule.

SPOUSE EDUCATION BENEFIT

If the Insured Person's Injury results in loss of life and a Principal Sum is payable under the Accidental Death and Dismemberment Benefit, we will pay an Education Benefit to his or her surviving Spouse as provided below.

The surviving Spouse, to qualify for the Education Benefit, must enroll in an Occupational Training program:

1) For the purpose of obtaining an independent source of income;

2) Within three (3) years of the date of the Insured Person’s death.

The Education Benefit is an amount equal to the lesser of:

1) The Expense Incurred for Occupational Training;

2) A Percentage of your Principal Sum; or

3) The Maximum Amount.

The expense must be incurred within three 48 months of the date of your death.

We will pay the Education Benefit due immediately after we receive proof that the Spouse has enrolled in an Occupational Training program.

Occupational Training means any:

1) Education;

2) Professional; or

3) Trade training;

Program which prepares the Spouse for an occupation for which he or she otherwise would not have been qualified.

Expense Incurred means:

1) The actual tuition charged, exclusive of room and board; and

2) The actual cost of the materials needed;

For the Occupational Training program.

If a Principal Sum is payable because of the Insured Person's death and there is no Surviving Covered Spouse, we will pay the Minimum Amount in accordance with the Payment of Claims provision.

Your amount of the Principal Sum is determined in the Schedule.

The Maximum Amount, Percentage of Principal Sum and Minimum Amount are shown in the Schedule.

REHABILITATION BENEFIT

If an Insured Person's Injury results in any loss, other than loss of life, payable under the policy, within 365 days after the date of accident, we will pay a benefit equal to the lesser of:

1) The Expense Incurred for Rehabilitative Training;

2) A Percentage of the Insured Person's Principal Sum; or

3) The Maximum Amount;

For Rehabilitative Training.

The expense must be incurred within two (2) years of the date of accident. The amount of Principal Sum is determined in the Schedule.

The Percentage of Principal Sum and Maximum Amount are shown in the Schedule.

Rehabilitative Training means any training which:

1) Is required due to the Insured Person's Injury; and

2) Prepares the Insured Person for an occupation in which he or she would not have engaged except for the Injury.

Expense Incurred means the actual cost:

1) Of the training; and

2) Of the materials needed for the training.

CONVERSION PRIVILEGE (INSURED PERSON ONLY)

If you cease to be covered under the policy because you cease to be eligible for coverage and:

1) The policy has not terminated; and

2) You have not failed to pay any required premium;

You have a conversion privilege as provided below.

The conversion right allows you to request coverage under a conversion policy from the Insurer, without giving medical evidence of insurability, to cover yourself but not your dependents.

Insurer, as used on this page, means us or another insurance company which has agreed with us to issue converted policies according to this conversion privilege.

You must:

1) Give the Insurer a Written Request for the converted policy; and

2) Pay the Insurer the initial premium;

Within 31 days after you cease to be covered under the policy.

The converted policy:

1) Will have the provisions, limitations and exclusions on the form the Insurer is issuing for this purpose at conversion;

2) Will provide coverage on a twenty-four hour-a-day basis;

3) Will provide benefits for accidental death and dismemberment alone;

4) Will take effect on the date you cease to be covered under the policy;

5) May exclude any condition excluded by the policy;

6) Will not pay for any loss covered by the policy;

7) Will provide a Principal Sum for yourself which will be the amount of your Principal Sum under the policy on the date of conversion, rounded to the nearest $1,000, subject a maximum amount of $250,000;

8) Will have premiums based on the Insurer's rates in effect for new applicants of your class and age at conversion.

The policy, as used on this page, means the group policy under which you are covered.

EXTENDED FELONIOUS ASSAULT BENEFIT

If, as the result of a Felonious Assault, You suffer a covered Loss under the Accidental Death and Dismemberment Benefit within 365 days after the date of Injury, we will pay an additional benefit equal to a Percentage of Your Principal Sum, not to exceed the Maximum Amount.

The Percentage of Principal Sum and Maximum Amount are shown in the Schedule.

Felonious Assault means a violent or criminal act directed at You during the course of:

1) A robbery, hold-up, kidnapping or criminal assault; or
2) An attempt at any of the above;

Which constitutes a felony under the law.

REPATRIATION BENEFIT

If an Insured Person's injury results in loss of life payable under the policy within 365 days after the date of accident, we will pay the lesser or:

1) The expense incurred for:
    a) Preparation of the deceased's body for burial or cremation; and
    b) Transportation of the deceased's body to the place of burial or cremation;
2) The Percentage of the Covered Person's Principal Sum; or
3) The Maximum Amount;

Provided that the Insured Person's death occurred more than 200 miles from the primary place of residence or outside the territorial limits of the state or country of permanent residence.

The amount of the Principal Sum is determined in the Schedule.

The Percentage of Principal Sum and Maximum Amount are shown in the Schedule.

DAY CARE BENEFIT

We will pay a Day Care Benefit for each Child if:

1) A Principal Sum is payable under the Accidental Death and Dismemberment Benefit because of the Insured Person's death and
2) Proof of enrollment in a Day Care Program is provided as described below.

Payment will be made to the person who has legal physical custody of the Child(ren) and who has primary responsibility for the Child(ren)'s Expenses. Payment will be made in accordance with the Claims provision of the Policy.

Proof of enrollment for each child in a Day Care Program may be in the form of, but will not be limited to, the following:

1) A copy of the child's approved enrollment application in a Day Care Program; or
2) Cancelled check(s) evidencing payment to a Day Care facility or Day Care Provider; or
3) A letter from the Day Care facility or Day Care provider stating that the child:
    a) Is attending a Day Care Program; or
    b) Has been enrolled in a Day Care Program and will be attending within 36 months of the date of the Insured Person's death.

Proof of enrollment must be sent to us prior to the last day of the 12th month on or next following the date of the Insured Person's death.

One Day Care Benefit payment will be made each year, for a maximum of 4 Day Care Benefit payments, for each Child.

The Day Care Benefit is the lesser amount of:

1) The Maximum Amount; or
2) An amount determined by applying the Day Care Percent to the amount of the deceased Person's Principal Sum.

We will pay the Minimum Amount stated in the Schedule in accordance with the Claims Provision for payment of benefits for loss of life if:

1) A Principal Sum is payable because of the Insured Person's death; and
2) No person qualifies as a Child for a Day Care Benefit.

Child means the Insured Person's unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age 13, and primarily dependent on the Insured Person for support and maintenance.

Day Care Program means a program of child care which:

1) Is operated in a private home, school or other facility; and
2) Provides, and makes a charge for, the care of children; and
3) Is licensed as a Day Care center or is operated by a licensed Day Care provider, if such licensing is required by the state of jurisdiction in which it is located; or
4) If licensing is not required, provides child care on a daily basis for 12 months a year.

The Maximum Amount, Minimum Amount, Percent and Principal Sum are shown in the Schedule.

CONTINUATION OF MEDICAL COVERAGE

If:

1) An Insured Person’s Eligible Dependents are covered under this policy; and
2) A Principal Sum is payable under the Accidental Death and Dismemberment Benefit because of the Insured Person’s death;

We will pay a Continuation of Medical Coverage Benefit provided the Insured Person’s Covered Dependents elect to continue Medical Coverage in accordance with the Consolidated Omnibus Reconciliation Act of 1998 (COBRA).

The Continuation of Medical Coverage Benefit will be paid in three annual installment amounts each equal to the lesser of:

1) A percentage of the Insured Person’s Principal Sum;
2) The actual cost of medical coverage for one year; or
3) The Maximum Amount.

The Continuation of Medical Coverage Benefit is payable to the Insured Person’s Covered Dependent’s Insurance Carrier on the date we have received the bill for such continuation of coverage.

If:

1) A Principal Sum is payable because of the Insured Person’s death; and
2) No person qualifies as a Covered Dependent; or
3) The Insured Person’s Covered Dependents to not elect to continue coverage pursuant to COBRA;

We will pay the Minimum Amount in accordance with the claim provision for payment of benefits for loss of life.

The Maximum Amount, Percent, and Minimum Amount are shown in the Schedule. The Principal Sum is determined in the Schedule.

COMA BENEFIT (INSURED PERSON ONLY)

If, as the result of an Injury, you:

1) Become Comatose within 30 days from the accident; and

2) Remain continuously Comatose for at least the number of days shown as the Waiting Period;

We will pay 2% of the Comatose Maximum Benefit Amount for each month after the Waiting Period that you remain in a Coma.

Payment will cease on the earliest to occur of:

1) The end of the month in which you die;

2) The end of the month in which you recover from the Coma; or

3) When the total payment equals the Comatose Maximum Benefit Amount.

The Comatose Maximum Benefit Amount equals the Principal Sum less all other payments under the Accidental Death and Dismemberment Benefit for the Injury.

Coma means complete and continuous:

1) Unconsciousness; and

2) Inability to respond to external or internal stimuli.

The amount of the Principal Sum is determined in the Enrollment Form on file with the Policyholder The Waiting Period is shown in the Schedule.

We will not pay more than the Principal Sum under this benefit, and the Accidental Death and Dismemberment Benefit for all losses including Coma, which are due to the same accident.

TRAUMATIC BRAIN INJURY BENEFIT

If the Insured Person's Injury results in a Traumatic Brain Injury within 90 days after the date of the accident and such Traumatic Brain Injury:

1) Requires that the Insured Person be hospitalized for at least 7 days during the first 60 days following the accident; and

2) Continues for 12 consecutive months,

We will pay the Principal Sum.

The Principal Sum is shown in the Schedule.

Traumatic Brain Injury means physical damage to the brain which, at the end of 12 consecutive months, a Physician has certified is:

1) Permanent, complete and irreversible; and

2) Prevents the Insured Person from performing all the substantial and material functions and activities of a person of like age and sex.

Physician means a legally qualified physician or surgeon other than a physician or surgeon who is related to the Insured Person by blood or marriage.

DEPENDENT CHILD DISMEMBERMENT BENEFIT

Dependent Child Dismemberment Benefit:

When is the Dependent Child Dismemberment Benefit payable?

If Your Dependent Child sustains a Loss, other than Loss of Life under the Accidental Death and Dismemberment Benefit, we will double the Principal Sum amount payable for the Loss.

This Benefit will be paid:

1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and

2) according to the General Provisions of The Policy.

We will not pay more than an amount equal to double the Principal Sum under this Benefit and the Accidental Death and Dismemberment Benefit combined for all Losses which are due to the same Injury.

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give us written notice of a claim within 30 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include your name and the policy number. Send it to our office in Hartford, Connecticut, or give it to our agent.

Claim Forms: When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to us in writing within 90 days after:

1) The end of a period of our liability for periodic payment claims; or

2) The date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

1) On a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or

2) Immediately after we receive the proof of loss following the end of our liability.

We will pay any other benefit due immediately after we receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of the Insured Person's life:

1) According to the beneficiary designation in effect at the time of the Insured Person's death; or

2) If no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at the time of death; or

3) To the survivors, in equal shares, in the first of the following classes to have a Survivor at the Insured Person's death:

   a) Spouse,

   b) Children,

   c) Parents,

   d) Brothers and sisters.

If there is no survivor in these classes, payment will be made to the Insured Person's estate.

All other benefits due and not assigned will be paid to the Insured Person, if living. Otherwise, the benefits will be paid according to the preceding paragraph.

Benefits will be paid into a checking account which will be owned by:

1) You; or

2) The beneficiary or beneficiaries named in writing by you.

The checking account owner may elect a lump sum payment by writing a check for the full amount in the checking account. However, a checking account will not be established for a benefit payable to your estate or for a Principal Sum that is less than $10,000.

If a benefit due is payable to:

1) Your estate; or

2) You or a beneficiary who is either a minor or not competent to give a valid release for the payment;

We may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to you or the beneficiary by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to you. The written decision will:

1) Give the specific reason or reasons for denial;

2) Make specific reference to the policy provision on which the denial is based;

3) Provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and

4) Provide an explanation of the review procedure.

On any denied claim, you or your representative may appeal to us for a full and fair review. The claimant may:

1) Request a review upon written application within 60 days of the receipt of claim denial;

2) Review pertinent documents;

3) Submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after we receive the request for review. The written decision will include specific reasons on which the decision is based.

Physical Examinations and Autopsy: While a claim is pending, we have the right at our expense:

1) To have the person who has a loss examined by a physician when and as often as we feel is necessary; and

2) To make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:

1) Before 60 days following the date proof of loss is sent to us;

2) After 3 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving your Written Request to the Policyholder. Your request takes effect on the date you execute it, regardless of whether you are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment we made in good faith before the Policyholder received your request.

Assignment: We will recognize any assignment you make under the policy, provided:

1) It is duly executed; and

2) A copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

POLICY TRANSITION PROVISIONS

We will cover each Prior Insured Person:

1) Upon payment of the required premium;

2) Under the provisions and conditions of The Policy.

The coverage under The Policy will be:

1) Effective on the Policy Effective Date stated on the face page; and

2) In the amount closest to the amount(s) of coverage he or she had under the Prior Policy.

Prior Policy means Policy No. 647541-B issued by Standard Insurance Company or ADD-S07126.

The Policy means Policy No. ADD-S07649 issued by Hartford Life and Accident Insurance Company.

Prior Insured Person means the Insured Person who was covered under the Prior Policy on the day before The Policy's Effective Date.

It is agreed and understood that this provision will not break the continuity of insurance on any Insured Person if:

1) He or she was insured under the Prior Policy as it was constituted prior to effective date of The Policy; and

2) He or she is immediately thereafter insured under The Policy, as stated in this provision.

A designation of beneficiary in effect on June 1, 2013 for the Prior Policy is considered to be a designation of beneficiary under The Policy which shall take effect on the effective date of The Policy. However, any designation of beneficiary made on or before the effective date of the policy in connection with the insurance provided by The Policy, in lieu of the designation of beneficiary made under the Prior Policy, takes effect on the effective date of The Policy.

Form PA-8684 (HLA)

Printed in U.S.A.

STATUTORY NOTICES

For Residents of Arkansas:

IMPORTANT NOTICE: ARKANSAS INSURED'S ACCESS TO INSURER

INFORMATION: This notice is to comply with Arkansas House Bill 1221. We are required by law to notify you of the complete addresses and phone numbers of the Arkansas Insurance Department, the insurance company's servicing office, and the agent. Below is this information: Arkansas Insurance Department, Consumer Services Division, 400 University, Tower Building, Little Rock, Arkansas 72204, Telephone: 1-800-852-5494. Servicing Office: Hartford Life Insurance Company, Special Risk Life and Health Department, P.O. Box 2250, Alpharetta, GA 30023, Telephone: (770) 753-0085. If you have any questions, contact your Hartford agent.

Form PA-7597-1

For Residents of California:

IF YOU HAVE A COMPLAINT, AND CONTACTS BETWEEN YOU AND THE INSURER OR AN AGENT OR OTHER REPRESENTATIVE OF THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM, THEN YOU MAY CONTACT: STATE OF CALIFORNIA INSURANCE DEPARTMENT, CONSUMER COMMUNICATIONS BUREAU, 300 SOUTH SPRING STREET, SOUTH TOWER, LOS ANGELES, CA 90013, 1-800-927-HELP. THE HARTFORD'S ADDRESS AND TOLL-FREE NUMBER IS: THE HARTFORD,

GROUP BENEFITS DIVISON, POLICYHOLDER SERVICES, PO BOX 2999, HARTFORD, CT 06104-2999, TELEPHONE: 1-800-572-9047.

Form PA-8292-1

For Residents of Florida:

NOTICE: The benefits of the policy providing your coverage are governed by the laws of a state other than Florida.

For Residents of Indiana:

IMPORTANT NOTICE: We are here to serve you. As our policyholder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. If for any reason you wish to contact The Hartford, please write to us at: The Hartford, Hartford Plaza, COGS-1-34, Hartford, CT 06115, Attn: James E. Parker. The Indiana Department of Insurance please write to: Public Information / Market Conduct, Indiana Department of Insurance, 311 W. Washington St., Suite 300, Indianapolis, IN 46204-2787, Consumer Hotline: 1-800-622-4461. In the Indianapolis Area: 1-317-232-2395.

Form PA-8104-2

For Residents of North Carolina:

THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY ISSUED OUT-OF-STATE. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

Form PA-8362

For Residents of Texas:

IMPORTANT NOTICE: You may call The Hartford's toll-free telephone number for information or to make a complaint at: 1-800-428-5711. You may also write to The Hartford at: P.O. Box 2999, Hartford, CT 06104-2999. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: 1-800-252-3439. You may write the Texas Department of Insurance at: P.O. Box 149104, Austin, TX 78714-9104. FAX # (512) 475-1771. Web: http://www.tdi.state.tx.us. E-mail: ConsumerProtection@tdi.state.tx.us. PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance. This notice is for information only and does not become a part or condition of this document.

AVISO IMPORTANTE: Para obtener informacion o para someter una queja: Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una queja al: 1-800-428-5711. Usted tambien puede escribir a The Hartford: P.O. Box 2999, Hartford, CT 06104-2999. Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al: 1-800-252-3439. Puede escribir al Departamento de Seguros de Texas: P.O. Box 149104, Austin, TX 78714-9104. FAX # (512) 475-1771. Web: http://www.tdi.state.tx.us. E-mail: ConsumerProtection@tdi.state.tx.us. DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI). Este aviso es solo para proposito de informacion y no se convierte en parte o condicion este documento.

Form PA-8422

For Residents of Wisconsin:

If you are a resident of the State of Wisconsin, the following notice applies: KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS. PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem. Hartford Life Insurance Companies, Group Benefits Division Policyholder Services, P.O. Box 2999, Hartford, CT 06104-2999. Telephone: 800-572-9047. You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by writing to: Office of the Commissioner of Insurance Complaints Department,

P.O. Box 7873, Madison, WI 53707-7873, 1-800-236-8517, 1-608-266-0103 or you can call 1-800-236-8517 outside of Madison, or 266-0103 in Madison, and request a complaint form.

Form PA-8560-4

Business Travel Accident and Global Health

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

SCHEDULE

Policy Number:	10-GTA-101903	
Policyholder Name:	T-Mobile	
Policyholder Address:	6500 Sprint Parkway Overland Park, KS 66251	
Policy Issue State:	Kansas	
Previous Policy No:	10-ETB-114056 10-GTA-101001	
Policy Period:	Policy Effective Date:	1/1/2022
	Policy Anniversary Date:	1/1/2022 1/1/2023 1/1/2024
	Policy Termination Date:	1/1/2025

Newly Acquired Corporations, Partnerships, or Sole Proprietorships

The premium for this Policy applies only to the Policyholder as constituted on the Policy Effective Date (or any renewal date of this Policy). However, any corporation, partnership, or sole proprietorship and acquired by the Policyholder after the Policy Effective Date (or any renewal date) will be considered a part of the Policyholder, or a Covered Affiliate or Subsidiary, as of the date of the acquisition, but only if the following conditions are both met by the Policyholder within a reasonable time after the acquisition date:

1) Policyholder must report to Us, in writing, the name of the newly acquired entity and all underwriting information We deem necessary to determine any additional premium required; and
2) It must agree to, and must pay, any required additional premium (or an appropriate portion thereof as agreed upon with Us).

If both conditions are not met within a reasonable time after the acquisition date, the newly acquired entity will not be considered a part of the Policyholder, or a Covered Affiliate or Subsidiary, and the employees from the newly acquired entity will not be considered as employees of the Policyholder or a Covered Affiliate or Subsidiary for Policy purposes, until the date both conditions are met.

PREMIUM

Policy Premium:	$297,048.
Premium Mode:	3-year annual installments due on the Effective Date and each Anniversary Date thereafter 1st annual installment of $99,016: January 1, 2022 – January 1, 2023 2nd annual installment of $99,016: January 1, 2023 – January 1, 2024 3rd annual installment of $99,016: January 1, 2024 – January 1, 2025

War Risk Premium: $5,000.00 per annual installment, already included in the installment premium above

DESCRIPTION OF ELIGIBLE CLASS(ES)

Class	Description Of Class(es)	Applicable Hazard Riders	Applicable Benefit Riders
1	All Executives of the Policyholder (Senior VP and above).	H-1, H-4, H-8(A), H-11, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
2	All Active US and International full-time non-bargaining and part-time employees of the Policyholder who work 20 or more hours per week.	H-3, H-4, H-8(B), H-10, H-15, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
3	All active US and international members of the Board of Directors of the Policyholder.	H-3, H-4, H-8(B), H-10, H-15, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
4	All eligible Spouses*, who are traveling with the Employee at the direction and expense of the Policyholder, who are not in any other Class.	H-7, H-21, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
5	All eligible Dependent Children, who are traveling with the Employee at the direction and expense of the Policyholder, who are not in any other Class.	H-7, H-21, H-40	B-4, B-7, B-11, B-13, B-26, B-32, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60

***Spouse** means any individual who, under applicable state law is recognized as a Spouse.

Spouse also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.

Spouse will include Your affidavit domestic partner provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of the Policy. You will continue to be considered affidavit domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

Spouse does not include any person who is insured as an Active Employee.

BENEFITS AND AMOUNTS

Class 1 **Accidental Death & Dismemberment**	**PRINCIPAL SUM** $3,000,000
Class 2 **Accidental Death & Dismemberment**	Five (5) times Annual Salary to a maximum of $3,000,000
Class 3 **Accidental Death & Dismemberment**	$500,000
Class 4 **Accidental Death & Dismemberment**	$50,000
Class 5 **Accidental Death & Dismemberment**	$25,000

Annual Salary means the Insured Person's base annual income and commission, but not including bonuses, overtime pay, and special compensation.

AGGREGATE LIMIT

$20,000,000 Per Covered Accident

HAZARD RIDER(S)

This Policy covers Injury resulting from the following hazard(s):

Identifier	Form Number	Description
H-1	Form BTA PA-10048	24-Hour Accident Protection Business and Pleasure Hazard Rider
H-3	Form BTA PA-10053	24-Hour Accident Protection While on Business Hazard Rider
H-4	Form BTA PA-10054	24-Hour Accident Protection While on a Policyholder Aircraft for Passenger, Pilot and Crew Hazard Rider
H-7	Form BTA PA-10050	24-Hour Family Relocation Trip Hazard Rider
H-8(A)	Form BTA PA-10055	24-Hour Hijacking or Sky-jacking Business and Pleasure Hazard Rider
H-8(B)	Form BTA PA-10055	24-Hour Hijacking or Sky-jacking Business Hazard Rider
H-10	Form BTA PA-10057	24-Hour Violent Act On a Trip—Business Only—Hazard Rider
H-11	Form BTA PA-10058	24-Hour Violent Act Hazard Rider
H-15	Form BTA PA-10062	Commutation Hazard Rider
H-21	Form BTA PA-10068	Family Travel Rider
H-40	Form BTA PA-10087	War Risk Hazard Rider

BENEFIT RIDER(S)

Identifier	Form Number	Description
B-4	Form BTA PA-10115	Adaptive Home & Vehicle Benefit Rider
B-7	Form BTA PA-10093	Bereavement Counseling Benefit Rider
B-11	Form BTA PA-10097	Carjacking Benefit Rider
B-13	Form BTA PA-10099	Coma Benefit Rider
B-19	Form BTA PA-10105	Day Care Benefit Rider
B-21	Form BTA PA-10107	Education Expense Rider
B-26	Form BTA PA-10112	Funeral Expense Rider
B-32	Form BTA PA-10119	Medical Emergency Evacuation Benefit Rider
B-33	Form BTA PA-10149	Mortgage Continuation Benefit Rider
B-38	Form BTA PA-10123 (KS)	Out of Country Medical Benefit Rider
B-39	Form BTA PA-10124	Paralysis Benefit Rider
B-49	Form BTA PA-10133	Rehabilitation Expense Benefit Rider
B-50	Form BTA PA-10134	Repatriation of Remains Benefit Rider
B-51	Form BTA PA-10135	Seat Belt and Airbag Benefit Rider
B-52	Form BTA PA-10136	Security Evacuation Benefit Rider
B-55	Form BTA PA-10139	Therapeutic Counseling Benefit Rider
B-60	Form BTA PA-10144	Worksite Modification Benefit Rider

BLANKET TRAVEL ACCIDENT POLICY

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

We will pay benefits according to the conditions of this Policy.

This is a legal contract between the Policyholder and Us. We agree to provide the rights and benefits of this Policy according to its conditions and provisions.

This Policy begins on the Policy Effective Date shown in the Schedule and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid. After the Policy Termination Date, this Policy may be renewed for additional periods of time by mutual written consent between Us and the Policyholder at the premium rates set by Us for the renewal period.

PLEASE READ THE POLICY CAREFULLY.

This Policy is delivered in and governed by the laws of the Policy Issue State, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). This Policy may be inspected at the office of the Policyholder.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS IS A LIMITED BENEFIT POLICY.

IT PROVIDES BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY. IT IS NOT INTENDED TO COVER ALL MEDICAL COSTS.

Signed for Hartford Fire Insurance Company at Hartford, Connecticut

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Non-Participating

Definitions

Accident, Accidental means a sudden, abrupt, and unexpected event.

Aircraft means a vehicle which:

1) has a valid Airworthiness Certificate issued by the FAA;
2) is being flown by a pilot with a valid license to operate the Aircraft.

Airworthiness Certificate means a valid and current "Standard Airworthiness Certificate" issued by the FAA.

Alcohol and Substance Abuse means the overindulgence in or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health or the welfare of others.

Ambulatory Surgical Center (ASC) or **Ambulatory Medical Center** means a licensed healthcare facility where surgical procedures or medical Treatment that does not require an overnight Hospital stay are performed by a Physician. The facility must:

1) be under the direct supervision of a Physician;
2) provide Treatment by Physicians and/or Medical Professionals; and
3) have written agreements in place with one or more Hospitals to immediately accept patients who develop complications.

An ASC is also known as an outpatient surgery center or a same day surgery center.

Automobile means a self-propelled private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to:

1) a sedan
2) station wagon
3) sport utility vehicle, and
4) a motor vehicle of the pickup, panel, van, camper, or motor home type

Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Benefit Plan means a policy or other benefit or service arrangement for medical or dental care, or providing accident or health coverage, under any of the following:

1) individual, group or blanket coverage, whether on an insured or self- funded basis;
2) Hospital or medical service organizations;
3) health maintenance organizations;
4) labor-management plans;
5) employee benefit organization plans;
6) association plans; or
7) any other "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended.

Business of the Policyholder means while on assignment by or at the direction of the Policyholder for the purpose of furthering the business of the Policyholder, but does not include any period of time:

1) while the Insured Person is working at his or her regular place of employment;
2) during the course of everyday travel to and from work; or
3) during an authorized leave of absence or vacation.

If an Insured Person's assignment to a location exceeds 365 days, such assignment will be deemed to change the Insured Person's residence and regular place of employment to the new location.

Civil Aircraft means a civilian or public Aircraft which:

1) has an Airworthiness Certificate;

2) is piloted by a person who has:

   a) a current pilot certificate which the appropriate Aircraft category rating for that Aircraft; and

   b) a current medical certificate which is appropriate for the operation of that Aircraft; and

3) is not operated by the militia, or armed forces of any state, national government or international authority.

A Civil Aircraft does not include a Policyholder Aircraft.

Coinsurance means the percentage of the Usual and Customary Charges incurred for Covered Medical Services payable by Us.

Coma, Comatose means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness by external or internal stimulation, as determined by a Physician.

Common Carrier means any air, land or water motorized Conveyance operated under a license for the transportation of fare-paying Passengers, including ridesharing programs. Common Carrier does not include courtesy transportation for which a charge is not made or cruise ships at sea more than 24 consecutive hours or any Conveyance, regardless of whether the Conveyance is licensed that is hired or used for a sport, gamesmanship, contest, or recreational activity. These Conveyances can include, but are not limited to, race cars, bobsleds, hunting vehicles, sightseeing vehicles, helicopters, fishing boats, parasails, paragliders, and boat cruises operating beyond 12 hours.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, that requires Hospital Confinement and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples include acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy; pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 24 consecutive hours.

Conveyance means any motorized craft, vehicle, or mode of transportation licensed or registered by a governmental authority with competent jurisdiction. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

Covered Accident means an Accident that occurs directly and independently of all other causes while coverage is in effect for an Insured Person resulting in a Covered Loss under the Policy for which benefits are payable.

The Insured Person must be participating in a Covered Hazard, as identified in the Schedule, when the Accident occurs.

Covered Hazard means those hazards set out in the Covered Hazards section of the Schedule, in which Insured Persons are provided insurance under the Policy.

Covered Loss means an accidental death, dismemberment, or other Injury covered under the Policy.

Covered Trip means Policyholder sponsored travel by air, land, or sea with a destination that is more than 100 miles from the Insured Person's primary residence. It includes the period time from the start of travel away from the Insured Person's place of primary residence or workplace, until the end of travel when the Insured Person returns to his primary residence or workplace, provided the duration of the travel does not last more than 365 days.

Deductible means the amount of Usual and Customary Charges for Covered Medical Services that must be incurred by the Insured Person before benefits become payable. The amount of the Deductible is shown in the Rider Schedule. Benefits are not payable for charges applied to the Deductible.

Dependent Child(ren) means:

1) an Insured Person's or Spouse's natural child, legally adopted child or stepchild;

2) a child placed into the Insure Person's or Spouse's custody for adoption (regardless of whether the adoption has become final);

3) a child for whom the Insured Person or Spouse is ordered by a court or administrative order to provide coverage regardless of whether he/she is the custodial or non-custodial parent; or

4) an Insured Person's or Spouse's foster child or any other child for whom the Insured Person or Spouse has been appointed legal guardian; or

5) any other child who lives with the Insured Person in a regular parent/child relationship and is dependent on the Insured Person for support and maintenance;

who is/are:

1) unmarried; and

2) under 18 years of age; or

3) a student age 18 or older but under age 26.

If an unmarried child is age 18 or older and is:

1) incapable of self-sustaining employment because of a mental or physical disability;

2) chiefly dependent on the Insured Person or Spouse for financial support and maintenance; and

3) proof has been provided of his/her disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist.

Diagnostic Exams mean any of the following major/advanced tests: angiogram, arteriogram, bone scintigraphy, CT, EEG, EKG, EMG, MRI, PET, SPECT, or thallium stress test. This definition does not include any lab test or x-ray.

Durable Medical Equipment means equipment of a type that is designed primarily for use, and used primarily, by people who are sick (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not sick, even if the items can be used in the Treatment of Emergency Sickness or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Eligible Class means any group of people listed in the Description of Eligible Class(es) shown in the Schedule.

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:

1) be staffed and equipped to handle trauma;

2) be under the direct supervision of a Physician;

3) provide Treatment by Physicians and/or Medical Professionals; and

4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Emergency Sickness means an illness or disease diagnosed by a Physician which causes a severe or acute symptom that, if not provided with immediate Treatment, would reasonably be expected to result in serious deterioration of the person's health, or place his/her life in jeopardy. Emergency Sickness also includes pregnancy and Complications of Pregnancy.

Experimental or Investigative Treatment means a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the Treatment, device or prescription medication is being used, including any Treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other government agency approval not received at the time the services are rendered.

FAA means:

1) the Federal Aviation Administration of the United States; or

2) the similar aviation authority for the country of the Aircraft's registry, if the country is recognized by the United States.

Geographic Area means the city, providence or region in which the service, procedure, devices, drugs, Treatment or supplies are provided or a greater area, if necessary, to obtain a representation cross-section of charges for a like

treatment, service, procedure, device, drug, or supply. Inside the United States, this would be based on the first three digits of the zip code.

Home Country means a country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, his or her Home Country will be the country that the Insured Person has declared to Us in writing as his or her Home Country.

Home Health Care means healthcare services provided by a Home Health Care Agency in the residence of an Insured Person, including, but not limited to, counseling services, home health aide services, Hospice Care, skilled nursing care, medical social services and Therapy Services. Services must be rendered under a plan of care that is established and reviewed regularly by a Physician.

Home Health Care Agency means an appropriately licensed home health care agency which:

1) is primarily engaged in providing home health services;
2) provides services under the supervision of a Physician or Medical Professional;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) maintains clinical records on all patients.

Hospice Care means specialized care, medical services and emotional support for an Insured Person who is in the last stages of an advanced illness, focusing on comfort and quality of life rather than cure.

Hospice Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides Hospice Care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times; and
3) is not mainly a place for care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Hospice Facility must follow certification by a Physician or hospice medical director that an Insured Person is terminally ill with less than 6 months to live if the Covered Loss runs its normal course. This definition does not include a nursing home, Rehabilitation Facility, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Hospital means an institution which:

1) operates pursuant to law;
2) primarily and continuously provides Medical Care and Treatment of sick and injured persons on an inpatient basis;
3) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
4) provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof, which is used primarily as:

1) a nursing home, convalescent home or Skilled Nursing Facility;
2) an alcohol or drug treatment facility; or
3) a place for rest, custodial care or for the aged.

Host Country means the country, other than an Excluded Country, in which the Insured Person is traveling while covered under the Policy.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes step-parent), grand-parent (includes step grand-parent), brother or sister (includes stepbrother or stepsister and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild.

Injury means bodily injury sustained by an Insured Person caused from a Covered Accident that:

1) occurs while this Policy is in force as to the Insured Person whose Injury is the basis of claim; and

2) occurs under the circumstances described in a Covered Hazard applicable to that Insured Person.

See the Schedule for applicability of all Covered Hazards and benefits. All Injuries sustained by one Insured Person in any one Covered Accident, including all related conditions and recurrent symptoms of the Injuries are considered a single Injury.

Inpatient means an Insured Person who is Confined and charged by a medical facility for room and board or is being held in a Hospital for a period of 24 consecutive hours or more. The requirement that an Insured Person be charged by the medical facility does not apply to Confinement in a Veteran's Administration Hospital or other Federal Government Hospital.

Insured Person means a person:

1) who is a member of an Eligible Class described in the Schedule;

2) for whom premium has been paid; and

3) while covered under this Policy.

Intensive Care Unit (ICU) means a specifically designated area of a Hospital that provides the highest level of Medical Care and:

1) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;

2) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;

3) is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;

4) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24-hour basis; and

5) has a Physician assigned to the unit on a full-time basis.

An Intensive Care Unit may include Hospital units with the following (or similar) names: burn unit; critical care unit; neonatal intensive care unit; cardiac care unit; or transplant unit.

An Intensive Care Unit is not any of the following step-down units: intermediate care unit; modified/moderate care unit; Observation Unit; progressive care unit; or sub-acute intensive care unit.

This definition does not include a private monitored room.

Kidnap, Kidnapped, or Kidnapping means the wrongful abduction and holding under duress or by fraudulent means of an Insured Person by any person or group making a ransom demand or series of ransom demands for the release of such Insured Person.

Leased Aircraft means any Aircraft not owned by the Policyholder but:

1) furnished for the use of and at the discretion of the Policyholder;

2) under the Policyholder's care, custody, or control for a stated period of time other than for a specific purpose or trip;

3) subject to a formal written lease agreement defining:

   a) all terms, conditions, and obligations of both parties during the term of the lease; and

   b) provisions for the safe return of the Aircraft to the owner, fair wear and tear expected;

4) with or without a pilot or crew furnished by the owner in attendance; and

5) with or without maintenance furnished by the owner.

Medical Care means necessary:

1) medical or surgical Treatment, services and supplies;

2) Hospital, nursing and ambulance services.

Each item of Medical Care must be:

1) prescribed by a Physician;

2) for the sole purpose of treating the Injury.

Medical Emergency Evacuation means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness:

1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained;

2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local Hospital or other medical facility; or

3) both 1) and 2) above.

A Medical Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Medically Necessary or **Medical Necessity** means a determination by the Insured Person's Physician that Treatment, service or supply provided to treat an Injury or Sickness is:

1) appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate treatment of the Injury or Sickness;

2) is commonly accepted as proper care or Treatment of the Injury or Sickness in accordance with the medical practices of the United States and federal guidelines;

3) can reasonably be expected to result in or contribute to the improvement of the Injury or Sickness; and

4) is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition of the Injury or the quality of the Medical Care provided.

The fact that a Physician may prescribe, order, recommend, or approve a treatment, service or supply does not, of itself, make the treatment, service, or supply medically necessary for the purpose of determining eligibility for coverage under the Rider.

The Medical Professional must be acting within the scope of his/her license. A Medical Professional does not include an Insured Person or any Immediate Family Member.

Medical Professional means a person who is appropriately licensed to provide Medical Care and Treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include an Insured Person or any Immediate Family Member.

Member of the Household means a person who maintains residence at the same address as the Insured Person at the time of the Injury.

Mental and Nervous Disorders means any condition, disease or disorder listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), where improvement can be reasonably expected with therapy.

This definition does not include conditions, diseases or disorders related to Substance Abuse.

Military Transport Aircraft means a transport Aircraft operated by:

1) the United States Air Mobility Command (AMC); or

2) a national military air transport service of any country.

Natural Disaster means an event, including, but not limited to, wind storm, rain, snow, sleet, hail, lightning, dust or sand storm, earthquake, tornado, flood, volcanic eruption, wildfire, or other similar event that:

1) is due to natural causes; and

2) results in severe damage such that the area in which loss occurs is declared a disaster area by a competent governmental authority having jurisdiction.

On the Premises of the Policyholder means on real estate owned, leased, controlled or under the management of the Policyholder and used by the Policyholder to conduct business.

Outpatient means an Insured Person who receives Treatment or services at a Hospital, Ambulatory Surgery Center (ASC), lab, medical clinic, Physician or Medical Professional's office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

Paralysis means the complete loss of muscle function in a part of the body as a result of neurological damage, as determined by a Physician.

Passenger(s) means a person not performing as a pilot, operator, or crew member of a Conveyance.

Physician means a provider or practitioner who:

1) is properly licensed or certified to provide care or Treatment under the laws of the state where he or she practices;
2) provides services that are within the scope of his or her license or certificate; and
3) is not the Insured Person, a Member of the Household of the Insured Person or an Immediate Family Member.

Policy means this insurance policy, certificate, the Schedule and all attached riders, amendments, endorsements or other papers.

Policy Period means the period between the Policy Effective Date and Policy Termination Date. These dates are shown on the Schedule.

Policyholder Aircraft means an Aircraft which is owned by the Policyholder, a Leased Aircraft or an Aircraft operated by or on behalf of the Policyholder.

Pre-existing Condition means a health condition for which an Insured Person has sought or received medical advice or Treatment from a Physician or Medical Professional at any time during the 12 months immediately preceding the Policy Effective Date of coverage under the Policy.

Rehabilitation Care Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides Rehabilitation Care Services;
2) is under the direct supervision of a Physician;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a rehabilitation care facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Relocation Trip means a trip which:

1) begins when the Insured Person or his or her Spouse or Dependent Child(ren) leave his or her former place of residence for the purpose of relocating to a new residence; and
2) ends when he or she arrives at his or her new place of residence;

provided such trip is due to the Insured Person's relocation which is at the request and expense of the Policyholder.

A Relocation Trip will not include any period of time in excess of 7 days of the Relocation Trip during which the Insured Person or his or her Spouse or Dependent Child(ren) take a vacation or Sojourn and/or Personal Deviation which substantially differs from the Relocation Trip.

Schedule means the benefits, benefit amounts, terms, limitations, and provisions of coverage selected by the Policyholder which is attached to and made a part of this Policy.

Scheduled Aircraft means a Civil Aircraft operated by a scheduled airline, which:

1) is licensed by the FAA for the transportation of Passengers for hire; and

2) publishes its flight schedules and fares for regular passenger service.

Sickness means an illness, disease or condition that impairs an Insured Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. Sickness also includes Complications of Pregnancy.

Skilled Nursing Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides skilled nursing care and related services 24 hours per day, 7 days per week;

2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times;

3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and

4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Skilled Nursing Facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Care Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Sojourn and/or Personal Deviation means non-business travel or activities undertaken while on the Business of the Policyholder, or during a Business Trip, but unrelated to furthering the Business of the Policyholder.

Spouse means any individual who is recognized as the spouse of the Insured Person, under applicable state law.

Spouse will also include a domestic partner or civil union partner as determined by any controlling legal authority or, in the absence of such authority, by agreement between Us and the Policyholder.

Surgical Replantation means the surgical reattachment of an arm, leg, hand, foot, finger, or toe that has been severed from an Insured Person's body.

Therapy Services means acupuncture, respiratory therapy, occupational therapy, physical therapy or speech therapy.

Transportation means moving an individual by the most efficient and available land, water or air Conveyance.

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

Trip means a trip taken by an Insured Person which begins when the Insured Person leaves his or her residence or place of regular employment for the purpose of going on the trip (whichever occurs last) and is deemed to end when the Insured returns from the trip to his or her residence or place of regular employment (whichever occurs first). However, the trip is deemed to exclude any period of time during which the Insured Person is on an authorized leave of absence or vacation or travel to and from the Insured Person's place of regular employment. This definition does not include the Insured Person's trip to a location that extends for more than 365 days. Such a trip will be deemed to change the Insured Person's residence or place of regular employment to the new location.

Usual and Customary Charge(s) means the average amount charged by most providers for Treatment, service or supplies in the Geographic Area where the Treatment, service or supply is provided.

Violent Act means any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime (including, but not limited to, robbery, hold-up, extortion, theft, Kidnapping, hostage-taking, assault, battery, sniping, murder, manslaughter, riot, or insurrection) that:

1) results in Injury to the Insured Person; and

2) is a felony or a misdemeanor in the jurisdiction in which it occurs.

We, **Us** or **Our** means the Hartford Fire Insurance Company.

POLICY EFFECTIVE AND TERMINATION DATES

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule at 12:01 AM Standard Time at the address of the Policyholder where this Policy is delivered.

Policy Termination Date. We may terminate this Policy by giving 31 days advance notice in writing to the Policyholder. Either We or the Policyholder may terminate this Policy on any premium due date by giving 31 days advance notice in writing to the other party.

This Policy may, at any time, be terminated by mutual written consent of the Policyholder and Us. This Policy terminates automatically on the earlier of:

1) the Policy Termination Date shown in the Schedule; or

2) the end of the Grace Period if premiums are not paid when due.

Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination

INSURED PERSON'S EFFECTIVE AND TERMINATION DATES

Insured Person's Effective Date. An Insured Person's coverage under this Policy begins on the latest of:

1) the Policy Effective Date;

2) the date for which the first premium for the Insured Person's coverage is paid; or

3) the date the person becomes a member of an Eligible Class as described in the Schedule.

A change in an Insured Person's coverage under this Policy due to a change in his or her Eligible Class, or Covered Hazard becomes effective on the later of:

1) when the change in his or her Eligible Class, or Covered Hazard occurs; or

2) if the change requires a change in premium, the date the changed premium is paid.

However, a change in coverage applies only with respect to a Covered Loss that occurs once the change becomes effective.

Insured Person's Termination Date. An Insured Person's coverage under this Policy ends on the earliest of:

1) the date this Policy is terminated (unless the Policyholder and Us agree, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);

2) the end of the Grace Period if premiums are not paid when due; or

3) the date the Insured Person ceases to be a member of any Eligible Class described in the Schedule.

Termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from a Covered Accident that occurred while the Insured Person's coverage was in force under this Policy.

PREMIUM

Premiums

Premiums are payable to Us as shown in the Schedule. We may change the required premiums due on any Policy anniversary date after the first Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least 31 days advance written notice.

We may change the required premiums as a condition of any renewal of this Policy. We may also change the required premiums at any time when any change affecting rates is made in this Policy. Any such change in this Policy will not take effect until any required additional premium is received by Us, except as otherwise agreed to in writing by the Policyholder and Us.

We may change the premium rates if:

1) there is a change in the Policy;

2) there is any change to state or federal law or inaction by state or federal law makers which affects Our liability under the Policy on a temporary or permanent basis;

3) Social Security Disability benefits are reduced or eliminated on a temporary or permanent basis due to the actual or threatened insolvency of the Social Security Disability Insurance Trust Fund;

4) there is a 10% increase or decrease in the number of insured;

5) the Policyholder adds or deletes a subsidiary, affiliated business entity or Policyholder Aircraft; or

6) there has been a material misstatement in the reported experience during the pre-sale process.

Renewal

This Policy may be renewed, subject to Our consent, by payment of premiums as they become due. The renewal premiums will be based on Our rates in effect at the time of renewal.

Grace Period

A grace period of 31 days will be provided for the payment of any premium due after the Initial Premium. This Policy will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the Grace Period.

If We expressly agree to accept late payment of a premium without terminating the Policy, the Policyholder will be liable to Us for any unpaid premiums for the time this Policy is in force.

No grace period will be provided if We receive notice to terminate this Policy prior to a premium due date.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT(S)

If the Insured Person's Injury results in any of the losses listed in the table below within 365 days after the date of the Covered Accident, We will pay the sum shown opposite the loss. We will not pay more than the Accidental Death or Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the same Covered Accident subject to the Age Reduction Schedule. The Accidental Death or Accidental Dismemberment Principal Sum amount is shown in the Schedule.

For Loss of:	Benefit:
Life	100% of the Accidental Death Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	100% of the Accidental Dismemberment Principal Sum
One Hand and One Foot	100% of the Accidental Dismemberment Principal Sum
One Hand and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
One Foot and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in Both Ears	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in One Ear	75% of the Accidental Dismemberment Principal Sum
One Arm or One Leg	75% of the Accidental Dismemberment Principal Sum
One Hand or One Foot	50% of the Accidental Dismemberment Principal Sum
Sight of One Eye	50% of the Accidental Dismemberment Principal Sum
Speech or Hearing in Both Ears	50% of the Accidental Dismemberment Principal Sum
Thumb and Index Finger on the Same Hand	25% of the Accidental Dismemberment Principal Sum
Hearing in One Ear	25% of the Accidental Dismemberment Principal Sum
One Thumb	10% of the Accidental Dismemberment Principal Sum

For purposes of this benefit:

1) **Loss of Arm** means Severance of an arm above the elbow joint, including the Severance of the entire arm.
2) **Loss of Both Feet, Loss of One Foot** means Severance of a foot or both feet above the ankle joint, including the Severance of an entire leg or any part of a leg that includes an entire foot.
3) **Loss of Both Hands, Loss of One Hand** means Severance of at least four whole fingers at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand) from one or both hands, including the Severance of an entire arm or any part of an arm that includes an entire hand.
4) **Loss of Fingers or Thumb** means Severance of more than one finger or the thumb at least at or proximal to the first interphalangeal joint of each finger.

5) **Loss of Hearing** means total and permanent loss of hearing in one or both ears which cannot be corrected by any means.

6) **Loss of Leg** means Severance of a leg above the knee joint, including the Severance of the entire leg.

7) **Loss of Sight of Both Eyes, Loss of Sight of One Eye** means total and permanent loss of sight or blindness which cannot be corrected by any means, or Severance of one or both eyes.

8) **Loss of Speech** means total and permanent loss of audible voice communication which cannot be corrected by any means.

9) **Severance** means the complete separation and dismemberment of the part from the body.

Surgical Replantation Benefit

If a limb or appendage is Surgically Replanted, the amount payable will be 50% of the amount which would have been paid for a Loss of such limb or appendage. If the Surgical Replantation fails to provide the person with at least 75% use of the limb or appendage, the Benefit Amount for the Loss will be paid, less any amount paid for the Surgical Replantation.

The amount payable depends on the type of Loss as shown above. All benefits are subject to the Accidental Dismemberment Principal Sum amount shown in the Schedule. We will not pay more than the Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the same Covered Accident subject to the Age Reduction Schedule.

Exposure and Disappearance

We will presume an Insured Person has died due to Injuries if, while insurance is in effect, the Insured Person dies as a result of exposure to the elements as a result of an Injury.

We will presume the Insured Person has died if, while insurance is in effect and after the forced landing, stranding, sinking, or wrecking of a vehicle:

1) the Insured Person disappears; and

2) the Insured Person's body is not found within 1 year(s) of disappearance; and

3) a valid death certificate is issued by a court of competent jurisdiction.

LIMITATIONS AND EXCLUSIONS

Economic Sanction

We will not provide coverage or pay benefits under this Policy to the extent, and only to the extent, that We are prohibited from providing coverage or making payment by any type of travel restriction, trade restriction, economic sanction, or embargo imposed by the United States government.

Limitation on Multiple Benefits

If an Insured Person suffers one or more Covered Losses from the same Covered Accident for which amounts are payable under all of the benefits provided by this Policy, the maximum amount payable under all of the benefits combined will not exceed the largest amount payable for one of those Covered Losses.

Limitation on Multiple Covered Hazards or Classes

If an Insured Person's Injury is caused by a Covered Accident that occurs while the Insured Person is covered under more than one Covered Hazard or Class, and if the same benefit applies to that Insured Person with respect to more than one such Covered Hazard or Class, then the Accidental Death or Accidental Dismemberment Principal Sum for that Insured Person for that Covered Accident will be determined as though the Covered Accident occurred while the Insured Person was covered under only one such Covered Hazard and Class. We will pay the benefits for the Covered Hazard and Class with the largest Principal Sum for that Insured Person.

Aggregate Limit

The Accidental Death or Accidental Dismemberment Principal Sum otherwise payable shall be reduced if more than one Insured Person suffers a loss as a result of the same Covered Accident, and if amounts are payable for those losses under all of the benefits provided by the Policy.

The Accidental Death or Accidental Dismemberment Principal Sum payable for all such losses for all Insured Persons under all those benefits combined will not exceed the amount shown as the Aggregate Limit in the Schedule or shown on the Hazard Rider Schedule. If the combined Accidental Death or Accidental Dismemberment Principal Sum otherwise payable for all Insured Persons must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual Accidental Death or Accidental Dismemberment Principal Sum otherwise payable for each Insured Person for all such losses under all those benefits combined.

Exclusions

Unless otherwise specified in the Policy, including any attached Riders, the Policy does not cover loss resulting from or for:

1) Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted Injury;
2) War or act of war, whether declared or undeclared;
3) Injury sustained while on active-duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard Service is not excluded, unless it extends beyond 31 days;
4) Injury sustained while on any Aircraft except a Civil Aircraft, or Military Transport Aircraft, unless specifically covered by a Hazard Rider;
5) Except when specifically covered by a Hazard Rider, Injury sustained while on any Aircraft:
    a) as a pilot, crewmember or student pilot;
    b) as a flight instructor or examiner;
    c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization covering any Eligible Class under the Policy; or
    d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
6) Injury sustained while the Insured Person is under the influence of any narcotics, drug or controlled substance, unless administered by or taken according to the instruction of a licensed Physician;
7) Injury sustained as a result of the Insured Person's voluntary intoxication through the use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;
8) Injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;
9) Injury sustained while the Insured Person is under the influence of intoxicants (as defined by the law of the jurisdiction in which the Injury occurred) while operating any vehicle or means of Transportation or Conveyance;
10) Injury sustained while the Insured Person is visually, manually or cognitively distracted or engaged in behavior which diverts attention and focus away from the roadway through use of a handheld mobile telephone or portable electronic device while operating any vehicle or means of Transportation or Conveyance or any form of distracted driving as defined by the law of the jurisdiction in which the Injury occurred;
11) Injury sustained by an Insured Person during or as a result of his or her participation in activities not sponsored or supervised by the Policyholder or any Extreme Sport or Extra-Hazardous Activities;
12) Sickness, disease, or bacterial or viral infection, or medical or surgical treatment thereof unless and only to the extent covered by Rider, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
13) Mental and Nervous Disorders;
14) Services for which no charge is normally made.

CLAIMS PROVISIONS

Notice of Claim

The person who has the right to claim benefits (the claimant, beneficiary or his or her representative) must give Us written Notice of a Claim within 30 days after a Covered Loss begins or as soon as reasonably possible.

Notice of claim may be submitted as instructed on the applicable form or mailed to Our home office in Hartford, CT. Notice given by or on behalf of an Insured Person to Us, or to Our authorized agent, with information sufficient to identify the Insured Person, shall be notice to Us. Failure to give notice within this time frame will not invalidate nor reduce any claim. The notice should include the Insured Person's name and the Policy Number.

Claim Forms

When We receive the notice of claim, We will send forms to the claimant for giving Us Proof of Loss. The forms will be sent within 10 days after We receive the notice of claim. If the forms are not received, the claimant will satisfy the Proof of Loss requirement if a written notice of the occurrence, character and extent of the loss is sent to Us.

Proof of Loss

Written Proof of Loss must be furnished to Us within 90 days after the date of the loss. If the claim is for loss of time due to disability, subsequent written proofs of the continuance of such disability must be furnished at such intervals as We may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

All Proof of Loss submitted must be satisfactory to Us and must include information which is required by Us to adjudicate the claim. In addition, the claimant must provide Us any Proof of Loss documentation specifically required in any relevant Rider. We reserve the right to request additional information reasonably related to the claim.

Time of Payment of Claims

We will pay any benefit due, other than benefits for which the Policy provides periodic payment, immediately after We receive Proof of Loss. Subject to due written Proof of Loss, all accrued benefits for which the Policy provides periodic payment will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which benefits are due, and any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of the proof.

Payment of Claims

We will pay any benefit due for loss of life:

1) according to the written beneficiary designation on file with the Policyholder; otherwise, if no beneficiary is named or no named beneficiary survives the Insured Person, We will pay
2) to the survivors in equal shares, in the first of the following classes to have a survivor at the Insured Person's death:
    a) Spouse;
    b) children;
    c) parents;
    d) brothers and sisters.

If there is no survivor in these classes or if there are legal impediments to determining who the survivors or beneficiaries are, payment will be made to the Insured Person's estate.

All other benefits due and not assigned will be paid to the Insured Person, if living. Otherwise, the benefits will be paid according to the preceding language.

If a benefit due is payable to:

1) the Insured Person's estate; or
2) the Insured Person or a beneficiary who is either a minor or not competent to give a valid release for the payment,

We may pay up to $1,000 of the benefit due to some other person whom We believe is entitled to the payment, and who is related to the Insured Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services unless the Insured Person requests otherwise in writing. The Insured Person must make the request no later than the time he or she files Proof of Loss.

Upon receipt of due written Proof of Loss, benefit payments for charges incurred by the Insured Person for covered medical services will be made directly to the provider at Our option. If any such charges have been paid by the Insured Person, the benefit payment for those charges will be made to the Insured Person upon written proof of payment.

Modified Payment of Claims

When We receive notice for losses suffered by an Insured Person whose residence is outside the United States, We may pay any benefits that may become payable under the Policy to the Policyholder, who:

1) will hold such payment in trust for the sole use and benefit of the Insured Person or his or her beneficiary or other person to whom such benefits are payable (the Payee), as described in the Payment of Claims provision within this section;
2) will transmit such payment to such Payee in accordance with the Payment of Claims and Time of Payment of Claims provisions of this section;
3) agrees that any such payment made by Us to the Policyholder constitutes a full discharge of Our liability with respect to the claim for which payment is made;
4) will alone assume full responsibility for the proper application or distribution of such payment; and
5) will indemnify, defend and hold Us harmless for any claims, demands, judgments, losses, costs, expenses, liabilities and damages whatsoever, including interest, penalties and legal fees, arising from or relating in any way to such payment or to the amount, application or distribution thereof; and
6) will, with respect to any application or disbursement of such payment in foreign currency, use the foreign exchange rate in effect at the Policyholder's payor bank on the date the benefits become payable to convert United States of America dollar-denominated currency into foreign currency.

Appealing Denial of Claims

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the Insured Person. This written decision will:

1) give the specific reason or reasons for denial;
2) make specific reference to Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

On any denied claim, an Insured Person or his representative may appeal to Us for a full and fair review. The claimant may:

1) request a review upon written request within 60 days of receipt of claim denial;
2) review pertinent documents; and
3) submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons for the decision on which the decision is based.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to have:

1) a claimant for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a claimant for whom a claim is made in case of death, where not prohibited by law.

Legal Actions

No legal action may start:

1) until 60 days after Proof of Loss has been given; or
2) more than 5 years after the time Proof of Loss is required to be given, unless otherwise required by law.

Assignment

This insurance may not be assigned. The Insured Person may not assign any of his or her rights, privileges, or benefits under this Policy. Benefit payments may be assigned as allowed in the Payment of Claims provision.

Workers' Compensation Coverage

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

GENERAL PROVISIONS

Entire Contract

The entire contract between the Policyholder and Us consists of this Policy and any other papers made a part of this Policy at issue.

Incontestability

In the absence of fraud, the validity of this Policy shall not be contested, except for nonpayment of premium, after it has been in force for two years from the Policy Effective Date.

Statements

In the absence of fraud, all statements made by the Policyholder and persons insured under this Policy will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing, s i g n e d by the person making it and a copy of it is given to the person who made it, or, in the event of the death or incapacity of the Insured Person, to the Insured Person's beneficiary or personal representative.

Changes

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made part of this Policy.

Noncompliance with Policy Requirements

Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Data Furnished by Policyholder

The Policyholder must maintain adequate records acceptable to Us and provide any information required by Us relating to this insurance, its premium, and any benefits claimed or paid hereunder.

Right to Audit

We will have the right to inspect and audit, at any reasonable time, all records and procedures of the Policyholder that may have a bearing on this insurance, its premium, and any benefits claimed or paid hereunder.

Certificates

If required by the laws of the state where this Policy is delivered, We will give certificates to the Policyholder for delivery to Insured Persons. The certificates will state the features of this Policy which are important to Insured Persons.

Conformity with State and Federal Law

Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Right to Receive and Release Needed Information

We have the right to decide in Our sole judgment what facts We need to administer this Policy. We may get needed facts from, or give them to, any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give Us any facts We need to determine coverage under this Policy or determine the correct payment of a claim.

Facility of Payment and Right to Recovery

If a payment made under another plan includes an amount that should have been paid under this Policy, We may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under this Policy, and We will not have to pay that amount again. If the amount of the payments made by Us is more than it should have paid under this Policy, We may recover the excess from any person(s) to or for whom We have overpaid, including insurance companies or other organizations. If benefits are overpaid, We may recover the amount overpaid by requesting a lump sum payment of the overpaid amount or reducing future benefits payable under this Policy.

New Entrants

This Policy will allow from time to time, that new eligible Insured Persons of the Policyholder be added to the Eligible Class(es) of Insured Persons originally insured under this Policy.

Misstatement of Age

If premiums for the Insured are based on age and the Insured Person has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. We require satisfactory proof of age before paying any claim.

Clerical Error

Clerical error, whether by the Policyholder or Us, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect nor extend the insurance of any Insured if that insurance would otherwise have ended or been reduced as provided in this Policy.

Policy Interpretation

Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. Therefore, We are a fiduciary for the Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under the Policy. This provision applies where the interpretation of the Policy is governed by ERISA.

Disclosure of Services

In addition to the insurance coverage, We may offer noninsurance benefits and services under this Policy.

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-1 — 24-Hour Accident Protection Business and Pleasure Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR ACCIDENT PROTECTION BUSINESS AND PLEASURE HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury anywhere in the world resulting from a Covered Loss any time while insured by the Policy and while the Insured Person is:

1) a Passenger on, boarding, or alighting from a Civil Aircraft or Military Transport Aircraft;
2) being struck or run down by an Aircraft;
3) operating or a Passenger on, boarding, alighting from, or being struck or run down by any Conveyance being used as a means of Transportation.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

In all other respects, the Policy remains the same

Signed for Hartford Fire Insurance Company at Hartford, Connecticut

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-3 — 24-Hour Accident Protection While on Business Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR ACCIDENT PROTECTION WHILE ON BUSINESS HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury resulting from a Covered Loss during a Trip and while on the Business of the Policyholder, not lasting for more than 365 days, including an Injury while:

1) operating or a Passenger on, boarding, alighting from, or being struck or run down by any Conveyance being used as a means of land or water Transportation, except:
   a) any such Conveyance the Insured Person has been hired to operate or for which the Insured Person has been hired as a crew member and while the Insured Person is performing as an operator or crew member on any such Conveyance; or
   b) any such Conveyance the Insured Person is operating, or for which the Insured Person is performing as a crew member, (including while on, boarding, alighting from, or being struck or run down by) for the Transportation of Passengers or property for hire, profit or gain; or
2) a Passenger on, boarding, or alighting from a Civil Aircraft or Military Transport Aircraft; or
3) being struck or run down by an Aircraft.

The benefits under this Rider also apply where the Sojourn or Personal Deviation involves one or more stops en route to the destination, and extensions time spent at the destination, that do not last longer than a total of 4 days.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-4 — 24-Hour Accident Protection While on a Policyholder Aircraft for Passenger and Pilot and Crew Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR ACCIDENT PROTECTION WHILE ON A POLICYHOLDER AIRCRAFT FOR PASSENGER AND PILOT AND CREW HAZARD

We will pay Policy benefits for the Hazard described in this Rider, if an Insured Person suffers an Injury as a result of a Covered Loss anywhere in the world during a Trip on the Business of the Policyholder:

1) if the Insured Person is operating or a Passenger on, boarding, alighting from, or being struck or run down by the Policyholder Aircraft, specified below, while such Insured Person

   a) is a Passenger; or

   b) is acting or training as a pilot, specified below, or crew member by or on behalf of the Policyholder, but only if such Insured Person is certified and licensed by a governmental authority with competent jurisdiction to operate or serve as a pilot or crew on such Policyholder Aircraft; or

2) due to any Passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

For purposes of this Rider, only the following Insured Person(s) are authorized as pilot(s):

Pilots on file with the Policyholder

The above-named pilot(s) must have a current and valid medical certificate and pilot certificate with a proper rating to fly such Aircraft.

The Policyholder Aircraft(s) covered by this Rider are:

Aircraft as specified by Policyholder

Newly Acquired Aircraft Coverage: The Policyholder Aircraft Passenger and Pilot and Crew Hazard shall apply to any Newly Acquired Aircraft from the date such Aircraft is delivered to the Policyholder, provided the Policyholder:

1) notifies Us within 30 days; and

2) pays any required premium for such coverage.

Substitute and Replacement Aircraft Coverage: The Policyholder Aircraft Passenger and Pilot and Crew Hazard shall apply to any Substitute Aircraft or Replacement Aircraft from the time such Aircraft is used as a temporary substitute by the Policyholder, provided the Policyholder Aircraft covered under the Policy is withdrawn from use due to its breakdown, repair, servicing, loss, or destruction.

LIMITATIONS AND EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

The following exclusions in the Policy do not apply to this Rider to the extent the Rider specifically covers them:

1) Injury sustained while on any Aircraft except a Civil Aircraft, or Military Transport Aircraft;
2) Injury sustained while on any Aircraft;
   a) as a pilot, crew member or student pilot;
   b) as a flight instructor or examiner;
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization covering any Eligible Class under the Policy.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Newly Acquired Aircraft means an Aircraft that is owned, leased for a period of more than 30 consecutive days, or operated by or on behalf of the Policyholder, which is acquired either in addition to or in place of any Policyholder Aircraft covered under the Policy prior to such acquisition.

Replacement Aircraft means any Aircraft which is:

1) of similar or lesser size, weight and performance as the Policyholder Aircraft covered under the Policy;
2) is not owned by the Policyholder;
3) is operated by a properly licensed pilot certified and licensed by a governmental authority with competent jurisdiction to operate; and
4) is used as a temporary substitute for the Policyholder Aircraft covered under the Policy.

Substitute Aircraft means any Aircraft which:

1) is of the same class as the Policyholder Aircraft covered under the Policy;
2) is not owned by the Policyholder;
3) is operated by a properly licensed pilot certified and licensed by a governmental authority with competent jurisdiction to operate;
4) is not more than 3 seats and also not more than 25% larger in passenger and crew member seat capacity than the aircraft withdrawn from normal use; and
5) is used as a temporary substitute for the Policyholder Aircraft covered under the Policy.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-7 — 24-Hour Family Relocation Trip Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR FAMILY RELOCATION TRIP HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person's Spouse or Dependent Child(ren) suffer(s) an Injury as a result of a Covered Loss which occurs anywhere in the world during a Relocation Trip.

A Relocation Trip will not include any period of time in excess of 14 days during which the Insured Person takes a vacation, or a Sojourn or Personal Deviation from the Relocation Trip.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-8(A) — 24-Hour Hijacking or Sky-jacking Business and Pleasure Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR HIJACKING OR SKY-JACKING BUSINESS AND PLEASURE HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury resulting from a Covered Loss which occurs during a Hijacking or Sky-jacking anywhere in the world. Coverage under this Rider shall continue while the Insured Person is subject to the control of the hijacker(s) and during travel directly to his or her residence or original destination.

DEFINITIONS

Hijacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger.

Sky-jacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger. It will also include any attempt at Sky-jacking and consequent exposure to the Insured Person.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-8(B) — 24-Hour Hijacking or Sky-jacking Business Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR HIJACKING OR SKY-JACKING BUSINESS HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury resulting from a Covered Loss which occurs during a Hijacking or Sky-jacking anywhere in the world while the Insured Person is on the Business of the Policyholder. Coverage under this Rider shall continue while the Insured Person is subject to the control of the hijacker(s) and during travel directly to his or her residence or original destination.

DEFINITIONS

Hijacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger.

Sky-jacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger. It will also include any attempt at Sky-jacking and consequent exposure to the Insured Person.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-10 — 24-Hour Violent Act On a Trip—Business Only—Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Violent Acts that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR VIOLENT ACT ON A TRIP—BUSINESS ONLY—HAZARD

We will pay the Policy benefits for the Hazard described in this Rider, if an Insured Person suffers an Injury as a result of a Violent Act that occurs during a Trip on the Business of the Policyholder, while the Insured Person is covered under the Policy.

This Hazard will not apply to a Covered Loss that results from a Violent Act committed by:

1) the Insured Person;
2) the Insured Person's Immediate Family Member;
3) an employee of the Policyholder;
4) a former employee of the Policyholder whose employment with the Policyholder ended less than 6 months before the date of the Violent Act;
5) a Member of the Household in which the Insured Person resides; or
6) any Insured Person currently eligible for coverage under the Policy.

With respect to Sojourn and Personal Deviation, this Rider only applies where the Sojourn or Personal Deviation:

1) does not depart more than 500 miles from the direct route or destination(s) with respect to the circumstances described herein; and
2) if it involves one or more stops en route to the destination and/or an extensions time spent at the destination, does not last longer than a total of 14 days or 25% of the time that would otherwise have been spent

whichever is less.

EXCLUSIONS

Any aviation exclusion is waived with respect to an Insured Person to whom this Hazard applies, but only with respect to an Injury sustained by the Insured Person under the circumstances described in this Rider. However, unless otherwise provided by this Policy, that exclusion is not waived if the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft, if the Accident causing such Injury occurs while the Insured Person is:

1) riding as a Passenger in any Aircraft not intended and/or licensed for the transportation of Passengers; or
2) performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
3) riding as a Passenger in a Policyholder Aircraft or in an Aircraft owned, leased or operated by the Insured Person's employer.

All other exclusions in the Policy apply.

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, a police report detailing the Violent Act must be provided.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-11 — 24-Hour Violent Act Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Violent Acts that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR VIOLENT ACT HAZARD

We will pay the Policy benefits for the Hazard described in this Rider, if an Insured Person suffers an Injury as a result of a Violent Act that occurs anywhere in the world while the Insured Person is covered under the Policy.

This Hazard will not apply to a Covered Loss that results from a Violent Act committed by:

1) the Insured Person;
2) the Insured Person's Immediate Family Member;
3) an employee of the Policyholder;
4) a former employee of the Policyholder whose employment with the Policyholder ended less than 6 months before the date of the Violent Act;
5) a Member of the Household in which the Insured Person resides; or
6) any Insured Person currently eligible for coverage under the Policy.

EXCLUSIONS

Any aviation exclusion is waived with respect to an Insured Person to whom this Hazard applies, but only with respect to an Injury sustained by the Insured Person under the circumstances described in this Rider. However, unless otherwise provided by this Policy, that exclusion is not waived if the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft, if the Accident causing such Injury occurs while the Insured Person is:

1) riding as a Passenger in any Aircraft not intended and/or licensed for the transportation of Passengers; or
2) performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
3) riding as a Passenger in a Policyholder Aircraft or in an Aircraft owned, leased or operated by the Insured Person's employer.

All other exclusions in the Policy apply.

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, a police report detailing the Violent Act must be provided.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-15 — Commutation Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

EXTRAORDINARY COMMUTATION HAZARD

We will pay the Policy benefits for the Hazard described in this Rider, for an Injury which occurs while the Insured Person is commuting directly between his or her residence and place of regular employment:

1) by Automobile or other Conveyance not normally used by the Insured Person for commuting; and
2) during a strike, power failure, major breakdown, or similar event which results in the discontinuance or interruption of one or more public transportation systems regularly used by the Insured Person;

on a regularly scheduled workday.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-21 — Family Travel Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

FAMILY TRAVEL HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when the Spouse or Dependent Child(ren) of the Insured Person suffer(s) an Injury resulting from a Covered Loss:

1) while accompanying the Insured Person or on his or her way to join the Insured Person on a Trip while on the Business of the Policyholder, including a Sojourn or Personal Deviation taken during the course of such Trip; and

2) when such Trip is authorized by and/or paid for in whole or in part by the Policyholder.

Benefits payable under this Hazard are subject to the Exclusions listed in the Policy.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-40 — War Risk Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

WAR RISK HAZARD

We hereby waive the exclusion "war or act of war, whether declared or undeclared," in the Exclusions section of the Policy, provided an Insured Person suffers a Covered Loss due to or contributed by declared or undeclared War occurring worldwide, except:

1) in the United States of America or the Insured Person's country of permanent residence; or
2) if the Insured Person is traveling within the geographical limits, territorial waters, or the airspace above a Designated War Risk Territory.

Coverage may be extended for Covered Losses due to or contributed by declared or undeclared War that occurs in the Designated War Risk Territory if the Policyholder reports actual exposure within these countries to Us as indicated below in the Reporting Requirements. Additional premium may apply.

This War risk coverage is subject to an Aggregate Limit per Covered Loss as shown in the Rider Schedule below.

Reporting Requirements

The Policyholder agrees to report in advance in writing, exposure of Insured Persons in the Designated War Risk Territory(ies). The report must include the name of each Insured Person exposed, his or her specific itinerary and designation(s) in the Designated War Risk Territory(ies), and the effective and termination dates of his or her exposure and Principal Sum amount. Additional premium may apply.

Changes in War Risk Territories

We may, with 10 days written notice to the Policyholder, make changes to the list of countries designated as Designated War Risk Territory(ies), that in Our opinion, are required to accurately reflect existing war risk conditions. We may also, at any Policy anniversary date, as measured annually from the Policy Effective Date, and with at least 10 days written notice to the Policyholder, request information regarding any/all travel by an Insured Person to countries other than the Insured Person's country of origin or country of citizenship.

Termination Date

War risk coverage ends on the earliest of:

1) the date the Policy terminates;
2) the date We receive written notice from the Policyholder of the Policyholder's intent to terminate War risk coverage (or on the date specified in the written notice, if later); or
3) the date specified in Our written notice to the Policyholder of Our intent to terminate War risk coverage (or 10 days after the date the written notice is received by the Policyholder, if later).

If War risk coverage terminates prior to the end of a period for which premium has already been paid, any unearned premium will be returned on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. Our failure to exercise any of Our rights under this coverage will not be deemed a waiver of these rights.

Termination of War risk coverage will not affect a claim for a Covered Loss that occurred while War risk coverage was in effect.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Designated War Risk Territory(ies) means Afghanistan, Iraq, Israel (West Bank/Gaza Strip), Libya, Somalia, Sudan, Syria, and Yemen or any country subject to the administration and enforcement of U. S. economic embargoes and trade sanctions by the Office of Foreign Assets Control (OFAC).

War means armed conflict, hostilities or warlike operations (whether war be declared or not) by order of any government or public authority including but not limited to invasion, acts of any enemy foreign to the nationality of the Insured Person or the country in (or over) which the act occurs, civil war, riot, rebellion, insurrection, revolution, overthrow of the legally constituted government, civil commotion assuming the proportions of (or amounting to) an uprising, military or usurped power, or explosion of war weapons.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-4 — Adaptive Home & Vehicle Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

ADAPTIVE HOME & VEHICLE MODIFICATION BENEFIT

If an Insured Person suffers an Injury, other than loss of life, that results in a loss payable under the Accidental Dismemberment, or Paralysis Benefit, We will pay an additional benefit that is the lesser of:

1) the Benefit Amount as indicated in the Rider Schedule; or

2) the actual cost

for Home Alteration and Vehicle Modification Expenses that are incurred within 24 months of the date of the Covered Accident that caused the Injury if an Insured Person:

1) did not require, prior to the date of the Covered Accident that caused the Injury, the use of a wheelchair or other adaptive device to be ambulatory; and

2) as a direct result of such Injury, the use of a wheelchair or other adaptive device to be ambulatory is now compulsory.

This benefit will be payable only if:

1) such Home Alterations are:
   a) made by a person(s) with experience in such alterations; and
   b) recommended by a recognized organization providing support and assistance to wheelchair or other adaptive device users; and

2) such Vehicle Modifications are:
   a) carried out by a person(s) with experience in Vehicle Modifications; and
   b) approved by the motor vehicle department of the state.

RIDER SCHEDULE

Adaptive Home & Vehicle Modification Benefit

Class:	**Benefit Amount:**
Classes 1, 2, 3, 4, 5	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Home Alteration means changes to the residence of the Insured Person that are necessary to make the residence accessible and habitable to the Insured Person.

Home Alteration and Vehicle Modification Expenses as used in this Rider mean one-time expenses that:

1) are charged for:

a) alterations to the Insured Person's residence that are necessary to make the residence accessible and habitable for a wheelchair-confined person or adaptive device user; or

b) modifications to an Automobile owned or leased by the Insured Person or modifications to an Automobile newly purchased for the Insured Person that are necessary to make the Automobile accessible to and/or driveable by the Insured Person;

2) do not include charges that would not have been made if no coverage existed; and

3) do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred.

Expenses incurred due to the alterations to the Automobile and residence of the Insured Person must:

1) be made on behalf of the Insured Person; and

2) be in compliance with any applicable laws or requirements for approval by the appropriate government authorities.

Vehicle Modifications means changes, including but not limited to installation of equipment to an Automobile that are necessary to make such Automobile accessible to or drivable by an Insured Person.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-7 — Bereavement Counseling Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

BEREAVEMENT COUNSELING BENEFIT

If the Insured Person suffers an accidental death or an accidental dismemberment or Paralysis for which an Accidental Death, or Accidental Dismemberment or Paralysis Benefit is payable under the Policy or if he or she goes into a Coma for which a Coma Benefit is payable, We will pay the Bereavement Counseling Benefit if an Insured Person or his or her Spouse and/or Dependent Child(ren) receives Bereavement Counseling.

We will pay the Bereavement Counseling Benefit Amount for each Bereavement Counseling session he or she attends, up to the Maximum Number of Sessions as found in the Rider Schedule.

Bereavement Counseling sessions must first begin within 365 days after the date of the Covered Accident. Benefits for any Bereavement Counseling session must be incurred within 2 year(s) after the date of the Insured Person's Covered Accident.

RIDER SCHEDULE

Bereavement Counseling Benefit

Class:	Benefit Amount:	Maximum Number of Sessions:
Classes 1, 2, 3, 4, 5	$250 per session	20

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, evidence of expenses incurred for services provided for Bereavement Counseling is required in order to receive benefits under this Rider.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Bereavement Counseling means treatment or counseling for the grief reaction resulting from an Insured Person's Covered Accident. Counseling must be provided by a licensed therapist, counselor, or psychiatrist who is registered or certified to provide psychological treatment or counseling.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-11 — Carjacking Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to a Carjacking that occurs on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

CARJACKING BENEFIT

We will pay an additional benefit amount under this Rider when the Insured Person suffers a Covered Loss for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit, Paralysis Benefit or Coma Benefit that results from a Carjacking of an Automobile that the Insured Person was operating or riding in as a Passenger (including getting in or out of such Automobile).

The amount payable under this Rider is the lesser of the Benefit Amounts shown in the Rider Schedule. Only one benefit is payable, the largest, under this Rider for all losses as a result of the same Carjacking.

Verification of the Carjacking must be a part of an official report of the Carjacking or be certified, in writing, by the investigating officer(s).

RIDER SCHEDULE

Carjacking Benefit

Class:	Benefit Amount:
Classes 1, 2, 3, 4, 5	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Carjacking means taking unlawful possession of an Automobile by means of force or threats against the person(s) then rightfully occupying such Automobile.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-13 — Coma Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

COMA BENEFIT

If an Injury renders the Insured Person Comatose within 365 days of the date of the Covered Accident, and if the Coma continues for a period of 30 consecutive days, We will pay a monthly benefit equal to the Monthly Benefit Amount shown in the Rider Schedule. No benefit is provided for the first 30 days of the Coma.

The benefit is payable monthly as long as the Insured Person remains Comatose due to the Injury, but ceases on the earliest of:

1) the end of the month in which the Insured Person dies;

2) the end of the month in which the Insured Person recovers from the Coma;

3) the end of the month in which the Monthly Benefit Period ends; or

4) the total payments equal the Maximum Benefit Amount.

We will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which We are liable when the Insured Person is Comatose for less than a full month.

If an Insured Person is in a Coma for which the Monthly Benefit Amount is payable and dies within 365 days after the Covered Accident, We will pay a lump sum equal to the Insured Person's Maximum Benefit Amount, less any benefit amount for Coma already paid.

We reserve the right, at the end of the first 30 consecutive days of Coma and as often as We may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured Person is Comatose, including, but not limited to, requiring an independent medical examination provided at Our expense.

RIDER SCHEDULE

Coma Benefit

Class:	Maximum Benefit Amount:	Monthly Benefit Amount:	Monthly Benefit Period:
Class 1	$3,000,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 2	Five (5) times Annual Salary to a maximum of $3,000,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 3	$500,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 4	$50,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 5	$25,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Monthly Benefit Period means the number of months as shown in the Rider Schedule during which the Insured Person remains in a Coma and for which the monthly Coma benefit is payable.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-19 — Day Care Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

DAY CARE BENEFIT

If the Accidental Death Benefit is payable under the Policy and the Insured Person has or is survived by one or more Children, We will pay a benefit on behalf of any Child of the Insured Person who:

1) is enrolled in a Day Care Program on the date of the Covered Accident causing the Insured Person's death and on the date of the Insured Person's death; or
2) enrolls in a Day Care Program within 365 days after the Insured Person's death. The benefit is payable annually for each year of the Child's enrollment in a Day Care Program, for a maximum of 4 Day Care Benefit payments for each Child.

The total amount of the benefit each year is equal to the least of:

1) the actual cost of care for that Child charged by that Day Care Program for that year;
2) the Percentage of the Accidental Death Principal Sum shown on the Rider Schedule; or
3) the Maximum Benefit Amount shown in the Rider Schedule.

The benefit will be paid to the person who has primary responsibility for the Child's Day Care Program expenses. The benefit is not payable for any period of enrollment in a Day Care Program before the date of the Accident that caused the Insured Person's death. The benefit is not payable for any period of enrollment after the earlier of:

1) the date the Child reaches 13 years of age; or
2) the date 4 year(s) after the later of the date of the Insured Person's death or the date the Child first enrolls in a Day Care Program.

RIDER SCHEDULE

Day Care Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4	10% of Accidental Death Principal Sum	$25,000

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, We will require proof of enrollment for each Child in a Day Care Program. Proof may be in the form of, but not be limited to, the following:

1) a copy of the Child's approved enrollment application in a Day Care Program; or
2) canceled check(s) or similar evidence of payment to the provider of the Day Care Program; or
3) a letter from the provider of the Day Care Program stating that the Child:
   a) is attending a Day Care Program; or

b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of the Insured Person's death.

Proof of enrollment and payment must be sent to Us prior to the last day of the 12th month following the date of the Insured Person's death and then annually thereafter.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Child, Children for the purposes of this Rider means the Insured Person's unmarried child, including a natural, step, foster or adopted child, from the moment of placement in the Insured Person's home, under age 13, and primarily dependent upon the Insured Person for support and maintenance.

Day Care Program means a program of childcare which:

1) is operated in a private home, school or other facility; and
2) provides, and receives compensation for, the care of children; and
3) is licensed as a child care center or is operated by a licensed child care provider, if such licensing is required by the state or jurisdiction in which it is located; or
4) if licensing is not required, provides childcare on a daily basis for 12 months a year.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-21 — Education Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

EDUCATION EXPENSE BENEFIT

If an Insured Person suffers a loss of life for which an Accidental Death Benefit is payable under the Policy, We will pay the following benefit(s):

Dependent Child Education

We will pay a benefit to or on behalf of any child of the Insured Person who meets the definition of Dependent Child on the date of the Covered Accident causing the Insured Person's death and on the date of the Insured Person's death and who, on the date of the Insured Person's death:

1) is a full-time student in any Institution of Higher Learning above grade 12; or
2) is in grade 12 and subsequently enrolls as a full-time student in an Institution of Higher Learning within 365 days after the date of the Insured Person’s death.

The benefit will be paid for each year of the Dependent Child's continuous enrollment as a full-time student in an Institution of Higher Learning, to a maximum of four (4) consecutive years or the date the Dependent Child reaches age 29, whichever comes first.

The total amount of the benefit each year is equal to the least of:

1) the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for that Dependent Child;
2) the Percentage of Accidental Death Principal Sum shown in the Rider Schedule based on the Insured Person’s Accidental Death Principal Sum on the date of the Covered Accident; or
3) the Maximum Annual Amount shown in the Rider Schedule.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment and payment for that term.

A Dependent Child who ceases to be enrolled as a full-time student becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment as a full-time student that begins before the date of the Insured Person's death.

Spouse Education

We will pay a benefit to or on behalf of the Spouse of the Insured Person who meets the definition of Spouse on the date of the Covered Accident causing the Insured Person's death and on the date of the Insured Person's death and who, for the purpose of obtaining an independent source of support or to enrich his or her ability to earn a living:

1) is enrolled in any Institution of Higher Learning or professional or trade training program on the date of the Insured Person’s death; or

2) subsequently enrolls in an Institution of Higher Learning or professional or trade training program within 30 months after the date of the Insured Person's death.

The benefit will be paid for each year of the Spouse's continuous enrollment in an Institution of Higher Learning or professional or trade training program, to a maximum of four (4) consecutive years.

The total amount of the benefit each year is equal to the least of:

1) the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for the Spouse;

2) the Percentage of Accidental Death Principal Sum shown in the Rider Schedule based on the Insured Person's Accidental Death Principal Sum on the date of the Covered Accident; or

3) the Maximum Annual Amount shown in the Rider Schedule.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment and payment for that term.

A Spouse who ceases to be enrolled as described above becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment that begins before the date of the Insured Person's death.

RIDER SCHEDULE

Dependent Child Education:

Class:	Percentage of Accidental Death Principal Sum:	Maximum Annual Amount:
Class 1, 2, 3, 4	10% of Accidental Death Principal Sum	$10,000

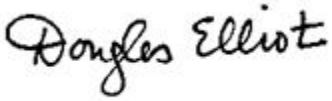
Spouse Education:

Class:	Percentage of Accidental Death Principal Sum:	Maximum Annual Amount:
Class 1, 2, 3, 4	10% of Accidental Death Principal Sum	$10,000

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*



Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-26 — Funeral Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

FUNERAL EXPENSE BENEFIT

If an Insured Person suffers a loss of life for which the Accidental Death Benefit is payable under the Policy, We will pay the Funeral Expense Benefit.

The Funeral Expense Benefit is equal to the least of:

1) the actual charges incurred for Funeral Expenses;
2) the Percentage of the Accidental Death Principal Sum shown in the Rider Schedule; or
3) the Maximum Benefit Amount shown in the Rider Schedule.

RIDER SCHEDULE

Funeral Expense Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	10% of Accidental Death Principal Sum	$10,000

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, We will require the following additional proof of loss:

1) a copy of the invoice for Funeral Expenses;
2) canceled check(s) or similar evidence of payment for such Funeral Expenses.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Funeral Expenses means:

1) transportation of the deceased from the death site to the funeral service site;
2) a container or casket for the deceased's remains to be placed in;
3) basic services of the funeral home and staff, including but not limited to embalming, interment, or cremation; and
4) the costs incurred for the purchase of a cemetery plot, tomb or mausoleum including plaque, tombstone or monument.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-32 — Medical Emergency Evacuation Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents and Emergency Sicknesses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

MEDICAL EMERGENCY EVACUATION BENEFIT

We will pay for Covered Medical Emergency Evacuation Expenses reasonably incurred if the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Medical Emergency Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, up to the Maximum Benefit Amount shown in the Rider Schedule for all Medical Emergency Evacuations due to all Injuries from the same Covered Accident or all Emergency Sicknesses from the same or related causes.

Benefits will not be payable, unless:

1) the Physician ordering the Medical Emergency Evacuation certifies that the severity of the Insured Person's Injury or Emergency Sickness requires a Medical Emergency Evacuation;
2) all Transportation arrangements made for the Medical Emergency Evacuation are by the most direct and economical method and route possible;
3) the charges incurred are Medically Necessary, and do not exceed the usual level of charges for similar Transportation, Treatment, services, or supplies in the locality where the expense is incurred; and
4) the charges incurred do not include charges that would not have been incurred if no insurance existed.

FAMILY TRAVEL BENEFIT

Following an Insured Person's Medical Emergency Evacuation, We will pay for expenses reasonably incurred:

1) to return to their current place of primary residence, the Insured Person's Spouse and any of the Insured Person's Dependent Children who were accompanying the Insured Person when the Medical Emergency Evacuation became necessary, with an attendant for the Dependent Children if necessary and if the Dependent Children are not accompanied by the Spouse; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person;
2) for lodging and meals for up to 10 days for the Insured Person's Spouse and Dependent Children in the area where the Insured Person is Confined, if:
    a) they were accompanying the Insured Person when the Medical Emergency Evacuation became necessary; and
    b) the place of Confinement is outside a 100-mile radius from the Insured Person's place of primary residence. We will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured Person's Medical Emergency Evacuation, and only while he or she remains so Confined. We will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, $200 per day for lodging and $100 per day for meals;
3) to bring one person chosen by the Insured Person to and from the Hospital or other medical facility where the Insured Person is Confined if:

a) the Insured Person is alone; and

b) the place of Confinement is outside a 100-mile radius from the Insured Person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket; and

4) for lodging and meals for up to 10 days for such person in the area of such place of Confinement, but:

a) only while the Insured Person remains so Confined; and

b) not to exceed $200 per day for lodging and $100 per day for meals.

EMERGENCY REUNION BENEFIT

Following a Medical Emergency Evacuation for which a Medical Emergency Evacuation Benefit is payable under this Rider, We will pay for the expenses reasonably incurred

1) to bring one person chosen by the Insured Person to and from the Hospital or other medical facility where the Insured Person is Confined if:

a) the Insured Person is alone; and

b) the place of Confinement is outside a 100-mile radius from the Insured Person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket; and

2) for lodging and meals for up to 10 days for such person in the area of such place of Confinement, but:

a) only while the Insured Person remains so Confined; and

b) not to exceed $200 per day for lodging and $100 per day for meals.

The total of all benefits outlined in this Rider may not exceed the Maximum Benefit Amount shown in the Rider Schedule.

RIDER SCHEDULE

Medical Emergency Evacuation Benefit

Class:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	Actual cost of the Medical Emergency Evacuation

LIMITATIONS AND EXCLUSIONS

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Benefits will not be payable unless We authorize in writing, or by authorized electronic or telephonic means, all expenses in advance, and services are rendered by Us or Our designated travel assistance provider. We reserve the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Us in advance. In the event the Insured Person refuses to be evacuated, We will not be liable for any expenses incurred after the date medical evacuation is recommended.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Medical Emergency Evacuation Expense(s) means an expense that:

1) is charged for a Medically Necessary Emergency Evacuation Service;

2) does not exceed the usual level of charges for similar Transportation, Treatment, services or supplies in the locality where the expense is incurred; and

3) does not include charges that would not have been made if no insurance existed.

Medically Necessary Emergency Evacuation Service means any Transportation, medical Treatment, medical service or medical supply that:

1) is an essential part of a Medical Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed;

2) meets generally accepted standards of medical practice; and

3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the Conveyance transporting the Insured Person.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-33 — Mortgage Continuation Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

MORTGAGE CONTINUATION BENEFIT

If the Accidental Death Benefit is payable under the Policy and the Insured Person has or is survived by a Spouse, We will pay an additional monthly Mortgage Continuation Benefit equal to the least of:

1) the actual cost of the monthly Mortgage payment;
2) the remainder of the Mortgage balance; or
3) the Monthly Benefit Amount shown in the Rider Schedule.

The benefit will be paid to the Spouse or appointed legal guardian of the youngest Dependent Child. The benefit is payable monthly until the earliest of:

1) the date the Insured Person's surviving Spouse dies;
2) the end of the calendar year when the youngest Dependent Child reaches age 18;
3) the date the Mortgage is paid in full;
4) the date the house is sold;
5) the end of the month in which the Monthly Benefit Period ends; or
6) the date the total payments equal the Maximum Benefit Amount.

RIDER SCHEDULE

Mortgage Continuation Benefit

Class:	Monthly Benefit Amount:	Monthly Benefit Period:
Class 1, 2, 3, 4	$1,000	12 months

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, the Mortgage company contact information, loan number, monthly Mortgage payment amount and loan balance are required in order to receive benefits under this Rider.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Mortgage means a loan that is secured by a single-family home, townhouse, condominium, or cooperative that is owned and used as a primary residence and includes any property taxes and insurance that may be included in the monthly payment.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-38 — Out of Country Medical Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

OUT OF COUNTRY MEDICAL EXPENSE BENEFIT

If the Insured Person is participating in a Covered Hazard outside of the United States or its territories for a period of less than 365 days, and the Insured Person suffers a Medical Emergency, We will pay the Out of Country Medical Expense Benefit.

The Out of Country Medical Expense Benefit Amount equals the Usual and Customary Charges incurred outside of the Insured Person's Country of Permanent Residence for Covered Medical Services that are Medically Necessary and received due to that Medical Emergency, up to the Maximum Amount per Insured Person. Benefits are payable for charges incurred within the Maximum Benefit Period shown in the Rider Schedule.

FOREIGN TRAVEL IMMUNIZATION BENEFIT

We will pay the Benefit Amount shown in the Rider Schedule, subject to all applicable conditions and exclusions, if the Insured Person is traveling during the course of a Covered Hazard outside of the United States or its territories and certain immunization or vaccination shots are required in order to enter the country. We will indemnify the Insured Person the Benefit Amount for each required immunization and/or vaccination up to the Benefit Maximum shown in the Rider Schedule.

MEDICAL EMERGENCY GUARANTEE CHARGE EXPENSE BENEFIT

If the Insured Person is participating in a Covered Hazard outside of the United States or its territories for a period of less than 365 days, and the Insured Person suffers a Medical Emergency for which the Usual and Customary Charges become payable under the Out of Country Medical Expense Benefit, and such Insured Person incurs a Hospital Admission Guarantee Charge, We will pay the actual expenses incurred for guarantee of the payment to the Hospital or the medical provider up to the Maximum Medical Emergency Guarantee Charge Expense Amount shown in the Rider Schedule.

COVERED MEDICAL SERVICES

Covered Medical Services under this Rider are as follows:

1) **Hospital:** the following services provided when the Insured Person is Confined in a Hospital:
   a) the daily room rate for a semi-private room when an Insured Person is Confined in a Hospital and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
   b) ancillary Hospital services and supplies including operating room, laboratory tests, Diagnostic Exams, anesthesia and medicines (excluding take home drugs) when Confined in a Hospital.
   c) the daily room rate when an Insured Person is Confined in a Hospital in a bed in the Intensive Care Unit and nursing services other than private duty nursing services.
2) **Private Duty Nurse:** private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN) while an Insured Person is Confined in a Hospital. These services must be ordered by a Physician.

3) **Emergency Room:** expenses incurred due to Treatment in an Emergency Room. Such expenses include the attending Emergency Room Physician's charges, x-rays, laboratory procedures, medications, use of the Emergency Room, and medical supplies. In the case of Injury, Emergency Room Treatment must begin within 72 hours of a Medical Emergency.

4) **Prosthesis:** artificial limbs, eyes, larynx, or other prosthesis for initial acquisition and fitting. We will not pay for repair or replacement of any prosthesis, unless due to a Covered Accident.

5) **Ambulatory Surgical Center or Ambulatory Medical Center:** Treatment including operating room, laboratory tests, anesthesia, medical supplies, and medicines (excluding take home drugs) provided in an Ambulatory Surgical Center or Ambulatory Medical Center.

6) **Physician:** expenses for Treatment provided by a Physician.

7) **Anesthesia:** expenses for pre-operative screening, anesthetics, and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.

8) **Durable Medical Equipment Rental:** expenses for rental of a wheelchair, orthopedic appliances, orthopedic braces, or other medical equipment that has therapeutic value for an Insured Person. We will not cover computers, motor vehicles, or modifications to a motor vehicle, ramps and installation costs, eyeglasses, and hearing aids. No benefits will be paid for rental charges in excess of the purchase price.

9) **Blood and Blood Products:** expenses for blood, blood products, artificial blood products, and transfusions of any blood or blood products.

10) **Ambulance:** expenses for transportation from the emergency site to the Hospital.

11) **Radiological Procedures:** Outpatient expenses for CAT Scan, MRI, x-ray, CT, PET, ultrasound, and other radiological procedures. Does not include dental x-rays.

12) **Outpatient Laboratory Tests:** expenses for laboratory tests provided when the Insured Person is not Confined in a Hospital and provided by a medical facility other than an Emergency Room or Ambulatory Surgical Center.

13) **Prescription Drug:** expenses for drugs prescribed by a Physician for the Treatment of Injury or Sickness and administered on an outpatient basis.

14) **Rehabilitation Care Facility:** expenses for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Care Facility and be under the direction of a Physician.

15) **Dental:** expenses including dental x-rays for the repair or Treatment of each Injured tooth that is whole, sound, and a natural tooth at the time of the Medical Emergency.

16) **Vision or Hearing Products:** eyeglasses, contact lenses, and hearing aids when damage occurs in a Medical Emergency that requires medical Treatment.

17) **Skilled Nursing Facility:** expenses for Confinement in a Skilled Nursing Facility if it begins within 5 consecutive days after an Insured Person is Confined in a Hospital as a result of a Medical Emergency. We will pay for Treatment if a Physician visits the Insured Person at least once every 30 days and certifies that the Confinement is Medically Necessary.

18) **Home Health Care:** expenses for Home Health Care beginning within 5 consecutive days after discharge from a Hospital, Skilled Nursing Facility, or Rehabilitation Care Facility.

19) **Manipulative Therapy**: expenses for chiropractic adjustment, spinal manipulation or neck manipulation performed by a licensed health care practitioner.

20) **Physical and Occupational Therapy**: expenses for physical or occupational therapy and an office visit connected with any such service.

RIDER SCHEDULE

Out of Country Medical Expense Benefit

Maximum Amount per Insured Person:	$250,000
Deductible:	$0 per Medical Emergency
Coinsurance:	100% of Usual and Customary Charges
Maximum Benefit Period:	52 weeks from the date of the Medical Emergency

Foreign Travel Immunization Benefit

Foreign Travel Immunization Benefit:	$100 per required immunization and vaccination required
Benefit Maximum:	$1,000

Medical Emergency Guarantee Charge Expense Benefit

Maximum Medical Emergency Guarantee Charge Expense Amount:	$10,000

LIMITATIONS AND EXCLUSIONS

Rider Exclusions

Unless otherwise specified in this Rider, in addition to the exclusions in the Policy, We will not pay Out of Country Medical Benefits for any loss, Treatment, or services resulting from, or contributed to, by:

1) elective or cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
2) Injury for which expenses are paid or payable under any automobile insurance policy without regard to fault; (This exclusion does not apply in any state where prohibited.);
3) Treatment or service provided by a private duty nurse;
4) Routine physical exams and medical services or wellness visits;
5) aggravation or re-Injury of a Pre-existing Condition;
6) manipulative therapy or chiropractic care;
7) Injury for which expenses are incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
8) Mental and Nervous Disorders;
9) Experimental or Investigative Treatment or procedures;
10) diagnosis or treatment of acne;
11) human organ or tissue transplants or treatment thereof.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Medical Services means the services covered by this Rider. Covered Medical Services are shown in the Rider Schedule and described in the Covered Medical Services provision.

Country of Permanent Residence means country or location in which the Insured Person maintains a primary permanent residence.

Hospital Admission Guarantee Charge means any charge or expense made by a Hospital prior to and as a condition of an Insured Person's admission to that Hospital.

Medical Emergency means a condition caused by an Injury or Sickness that meets all of the following criteria:

1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place his or her life in jeopardy;

2) the severe or acute symptom occurs suddenly and unexpectedly; and

3) the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom and under the circumstances described in a Covered Hazard:

   a) applicable to that person; and

   b) to which this Rider applies.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-39 — Paralysis Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

PARALYSIS BENEFIT

We will pay the percentage of the Maximum Benefit Amount shown below if Injury to the Insured Person results in any one of the types of loss(es) specified below within 365 days of the date of the Covered Accident that caused the Injury, provided that the Paralysis is diagnosed by a Physician as reasonably expected to continue for the duration of his or her lifetime.

If an Insured Person dies within 365 days of the Covered Accident, then We will pay a lump sum equal to the Insured Person's Maximum Benefit Amount shown in the Rider Schedule, less any Benefit Amount for Paralysis already paid.

RIDER SCHEDULE

Class:	**Maximum Benefit Amount**
Class 1	$3,000,000
Class 2	Five (5) times Annual Salary to a maximum of $3,000,000
Class 3	$500,000
Class 4	$50,000
Class 5	$25,000
Loss	**Class 1, 2, 3, 4, 5**
Quadriplegia	100% of the Maximum Benefit Amount
Triplegia	75% of the Maximum Benefit Amount
Paraplegia	75% of the Maximum Benefit Amount
Hemiplegia	50% of the Maximum Benefit Amount
Uniplegia	25% of the Maximum Benefit Amount

LIMITATIONS AND EXCLUSIONS

Rider Exclusions

If an Insured Person suffers a loss for which a benefit is payable under more than one of the following provisions: Accidental Death and Dismemberment Benefit; or only one benefit, the one which would pay the largest benefit amount, will be paid.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Hemiplegia means the complete and irreversible paralysis of the upper and lower Limbs of the same side of the body.

Limb, Limbs means entire arm or entire leg.

Paraplegia means the complete and irreversible paralysis of both lower Limbs.

Quadriplegia means the complete and irreversible paralysis of both upper and both lower Limbs.

Triplegia means the complete and irreversible paralysis of three Limbs.

Uniplegia means the complete and irreversible paralysis of one Limb.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-49 — Rehabilitation Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

REHABILITATION EXPENSE BENEFIT

If the Insured Person is participating in a Covered Hazard and suffers a Covered Accident for which an Accidental Dismemberment or Paralysis benefit is payable under the Policy, We will reimburse the Insured Person for Covered Rehabilitative Expenses that result from the Injury causing the dismemberment or Paralysis up to the Maximum Benefit Amount shown in the Rider Schedule for all Injuries caused by the same Covered Accident. The Covered Rehabilitative Expenses must be incurred within 2 years after the date of the Covered Accident causing the Injury.

RIDER SCHEDULE

Rehabilitation Expense Benefit

Class:	Maximum Benefit Amount:
Classes 1, 2, 3, 4, 5	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Rehabilitative Expense(s) means expenses that:

1) are charged for a Medically Necessary Rehabilitative Training Service of the Insured Person performed under the care, supervision or order of a Physician;
2) do not exceed the usual level of charges for similar Treatment, supplies, or services in the locality where the expenses are incurred (for a Hospital room and board charge, does not exceed the most common charge for Hospital semi-private room and board in the Hospital where the expense is incurred); and
3) does not include charges that would not have been made if no insurance existed.

Medically Necessary Rehabilitative Training Service means any medical service, medical supply, medical Treatment or Hospital Confinement (or part of a Hospital Confinement) that:

1) is essential for physical rehabilitative training due to the Injury for which it is prescribed or performed;
2) meets generally accepted standards of medical practice; and
3) is ordered by a Physician.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-49 — Repatriation of Remains Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

REPATRIATION OF REMAINS BENEFIT

If an Insured Person suffers an Injury or Emergency Sickness that results in loss of life while covered under the Policy, We will pay for certain expenses incurred as a result of such death including, but not limited to, the following:

1) the expense incurred for the preparation of the deceased's body for burial or cremation;
2) the most economical coffin or receptacle adequate for transporting the remains; and
3) transportation of the deceased's body to the place of burial or cremation;

up to the Maximum Benefit Amount shown in the Rider Schedule below, provided that the death of the Insured Person occurred outside a 100-mile radius from his or her current place of primary residence.

FAMILY TRAVEL BENEFIT

Following an Insured Person's death for which a Repatriation of Remains benefit is payable under this Rider, We will pay for expenses reasonably incurred:

1) to return to their current place of primary residence, the Insured Person's Spouse and any of the Insured Person's Dependent Children who were accompanying the Insured Person when his or her death occurred, with an attendant for the Dependent Children if necessary and if the Dependent Children are not accompanied by the Spouse; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person; and
2) for lodging and meals for up to 10 days for the Insured Person's Spouse and Dependent Children in the area where the Insured Person's death occurred, if they were accompanying the Insured Person at that time. We will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured Person's death, and only prior to the repatriation of his or her remains. We will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, $200 per day for lodging and $100 per day for food.

IDENTIFICATION AND ESCORT EXPENSE BENEFIT

If an Insured Person suffers an Injury or an Emergency Sickness that results in loss of life and the Repatriation of Remains Benefit is payable, We will pay for expenses reasonably incurred if an Immediate Family Member or authorized representative incurs Identification Expenses or Escort Expenses while:

1) en route and during the stay in the city or town where the Insured Person's body is located, including transportation by the most direct route by a licensed Common Carrier to and from such location, but not to exceed the cost of one round-trip economy airfare ticket; and
2) for lodging and meals for up to 10 days for such person in the area where the Insured Person's death occurred, and not to exceed $200 per day for lodging and $100 per day for meals.

The total of all benefits outlined in this Rider may not exceed the Maximum Benefit Amount shown in the Rider Schedule.

RIDER SCHEDULE

Repatriation of Remains Benefit

Class:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	Actual cost of the Repatriation of Remains

LIMITATIONS AND EXCLUSIONS

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Benefits will not be payable unless We authorize in writing, or by authorized electronic or telephonic means, all expenses in advance, and services are rendered by Us or Our designated travel assistance provider. We reserve the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Us in advance. In the event the Insured Person refuses to be evacuated, We will not be liable for any expenses incurred after the date medical evacuation is recommended.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Escort Expenses mean expenses for an Immediate Family Member or authorized representative to join the Insured Person's body during the repatriation to the Insured Person's place of permanent residence.

Identification Expenses mean expenses incurred by an Immediate Family Member or authorized representative when identifying the remains of the Insured Person.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-49 — Seat Belt and Airbag Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

SEAT BELT BENEFIT

If an Insured Person suffers a loss of life for which the Accidental Death Benefit is payable under the Policy and the Covered Accident causing death occurs while the Insured Person is operating, or riding as a Passenger in, an Automobile and wearing a properly fastened Seat Belt, We will pay the Seat Belt Benefit.

The Seat Belt Benefit is equal to the lesser of:

1) the Percentage of Accidental Death Principal Sum shown in the Rider Schedule; or
2) the Maximum Benefit Amount shown in the Rider Schedule.

AIRBAG BENEFIT

If the Insured Person is wearing a Seat Belt and received a payment as indicated above, We will pay the Airbag Benefit if:

1) the Insured Person was positioned in a seat equipped with a factory installed Airbag;
2) the Insured Person was properly strapped in the Seat Belt when the Airbag inflated; and
3) the police report establishes that the Airbag inflated properly upon impact.

The Airbag Benefit is equal to the lesser of:

1) the Percentage of Accidental Death Principal Sum shown in the Rider Schedule; or
2) the Maximum Benefit Amount shown in the Rider Schedule.

LIMITED BENEFIT

If a police report is not available, or it is unclear whether the Insured Person was wearing a Seat Belt, or positioned in a seat protected by a properly functioning and properly deployed Airbag, We will pay a limited benefit of $1,000.

RIDER SCHEDULE

Seat Belt Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	25% of Accidental Death Principal Sum	$50,000

Airbag Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	25% of Accidental Death Principal Sum	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Airbag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications that inflates upon collision to protect an individual from injury and death. An Airbag is not considered a Seat Belt.

Seat Belt means:

1) an unaltered belt, lap restraint, or shoulder restraint installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications; or

2) a child restraint device that meets the standards of the National Safety Council and is properly secured and utilized in accordance with applicable state law and the recommendations of its manufacturer for children of like age and weight.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-49 — Security Evacuation Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

SECURITY EVACUATION BENEFIT

If, as a result of an Occurrence that takes place while the Insured Person is covered under the Policy and participating in a Covered Hazard, and while traveling outside his or her Home Country, an Insured Person requires a Security Evacuation, We will pay benefits for the Transportation of the Insured Person to the Nearest Place of Safety. The determination that an Insured Person requires a Security Evacuation must be made by a Designated Security Consultant and all arrangements must be made by Our designated travel assistance provider.

Benefits will be payable for eligible expenses up to the Maximum Benefit Amount shown in the Rider Schedule. Eligible expenses are for Transportation to the Nearest Place of Safety and Related Costs necessary to ensure the Insured Person's safety and well-being as determined by the Designated Security Consultant. Security Evacuation benefits are payable only once per Occurrence.

Benefits will also be payable for Transportation and Related Costs within 7 days of the Security Evacuation to the following location(s) as chosen by the Insured Person:

1) back to the Host Country if return is safe and permitted;
2) the Insured Person's Home Country;
3) where the Insured Person is currently permanently assigned by the Policyholder;
4) where the Policyholder is located; or
5) where the entity that sponsored the Insured Person's trip is located.

Benefits will be payable for consulting services by Designated Security Consultant for seeking information on Missing Person or Kidnapping cases if the Insured Person is deemed Kidnapped or a Missing Person by local or international authorities. This benefit is subject to the Maximum Benefit Amount as shown in the Rider Schedule.

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Our designated travel assistance provider is not responsible for the availability of Transportation services. If possible, the Insured Person's Common Carrier tickets will be used. Where a Security Evacuation becomes impractical because of hostile or dangerous conditions, a Designated Security Consultant will endeavor to maintain contact with the Insured Person until a Security Evacuation becomes viable.

RIDER SCHEDULE

Security Evacuation Benefit

Class:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	Actual cost of the Security Evacuation up to a maximum amount of $100,000

LIMITATIONS AND EXCLUSIONS

Right of Recovery

For the purpose of this Rider, if, after a Security Evacuation is completed, it becomes clear that the Insured Person was an active participant in the events that led to an Occurrence, We have the right to recover all Transportation and Related Costs from the Insured Person.

Excess Provision

Benefits payable for the eligible expenses under this Rider will be limited to that part of the eligible expense, if any, which is in excess of the total benefits payable for the same Security Evacuation under any other valid and collectible insurance or other indemnity. If the other valid and collectible insurance or indemnity provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose coverage has been in effect for the longer period of time at the date of the Security Evacuation.

For purposes of this Rider, an Insured Person's entitlement to other valid and collectible insurance or indemnity will be determined as if this Rider did not exist and will not depend on whether timely application for benefits from other valid and collectible insurance or indemnity is made by or on behalf of the Insured Person.

Benefits under this Rider will be reduced to the extent that benefits for expenses are covered by any other valid and collectible insurance or indemnity whether or not a claim is made for such benefits.

Changes in Terms and Conditions

The terms and conditions of this Rider, including but not limited to the definition of Excluded Countries, may be changed at any time to reflect conditions that, in Our opinion, constitute a change in the Policyholder's Security Evacuation exposure. We will give the Policyholder written notice of any change in the terms and conditions of this Rider at least 10 days in advance of the effective date of the change.

Exclusions

Unless otherwise specified in this Rider, in addition to the exclusions in the Policy, no benefits are payable under this Rider for charges, fees or expenses:

1) payable under any other provision of, or Rider to, the Policy to which this Rider is attached;
2) that are recoverable through the Insured Person's employer;
3) arising from or attributable to an actual fraudulent, dishonest or criminal act committed or attempted by an Insured Person, acting alone or in collusion with others;
4) arising from or attributable to an alleged:
    a) violation of the laws of the Host Country by an Insured Person; or
    b) violation of the laws of the Insured Person's Home Country;

    unless the Designated Security Consultant determines that such allegations were intentionally false, fraudulent and malicious and made solely to achieve a political, propaganda and/or coercive effect upon or at the expense of the Insured Person;
5) due to the Insured Person's failure to maintain and possess duly authorized and issued required travel documents and visas;
6) arising from an Occurrence which took place in an Excluded Country;
7) for repatriation of remains expenses;
8) for common or endemic or epidemic diseases or global pandemic disease as defined by the World Health Organization;
9) for medical services;
10) for monies payable in the form of a ransom if a Missing Person case evolves into a Kidnapping;
11) arising from or attributable, in whole or in part, to a debt, insolvency, commercial failure, the repossession of any property by any title holder or lien holder or any other financial cause;

12) arising from or attributable, in whole or in part to non-compliance by the Insured Person with regard to any obligation specified in a contract or license; or

13) due to military or political issues if the Insured Person's Security Evacuation request is made more than 7 days after the Appropriate Authority(ies) Advisory was issued.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider

Advisory means a formal recommendation by the Appropriate Authorities that the Insured Person or citizens of his or her Home Country or citizens of the Host Country leave the Host Country.

Appropriate Authority(ies) means the government authority(ies) in the Insured Person's Home Country or the government authority(ies) of the Host Country.

Designated Security Consultant means an employee of a security firm under contract with Our designated travel assistance provider who is experienced in security and measures necessary to ensure the safety of the Insured Person(s) in his or her care.

Excluded Countries means the following countries from which Security Evacuations are not available under this Rider: Iraq, Afghanistan, Pakistan, Israel (West Bank and Gaza Strip), Iran, Somalia and Chechnya or] any country subject to the administration and enforcement of U. S. economic embargoes and trade sanctions by the Office of Foreign Assets Control (OFAC).

Imminent Physical Danger means the Insured Person is subject to possible physical injury or sickness that could result in grave physical harm or death.

Missing Person means an Insured Person who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authority(ies).

Nearest Place of Safety means a location determined by the Designated Security Consultant where:

1) the Insured Person can be presumed safe from the Occurrence that precipitated the Insured Person's Security Evacuation; and

2) the Insured Person has access to transportation; and

3) the Insured Person has the availability of temporary lodging, if needed.

Occurrence means any of the following situations in which an Insured Person finds himself or herself while covered by the Policy:

1) expulsion from a Host Country or being declared persona non-grata on the written authority of the recognized government of a Host Country;

2) political or military events involving a Host Country, if the Appropriate Authorities issue an Advisory stating that citizens of the Insured Person's Home Country or citizens of the Host Country should leave the Host Country;

3) Verified Physical Attack or a Verified Threat of Physical Attack from a third party;

4) Natural Disaster within 7 days of an event;

5) the Insured Person had been deemed Kidnapped or a Missing Person by local or international authorities and, when found, his or her safety and/or well-being are in question within 3 days of his or her being found;

6) Our designated travel assistance provider/Designated Security Consultant recommends an evacuation.

Related Cost(s) means food, lodging and, if necessary, physical protection for the Insured Person during Transportation to the Nearest Place of Safety.

Security Evacuation means the extrication of an Insured Person from the Host Country due to an Occurrence which results in the Insured Person being placed in Imminent Physical Danger.

Verified Physical Attack means deliberate physical harm of the Insured Person confirmed by documentation or physical evidence.

Verified Threat of Physical Attack means a threat against the Insured Person's health and safety as confirmed by documentation and/or physical evidence.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-55 — Therapeutic Counseling Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

THERAPEUTIC COUNSELING BENEFIT

We will pay for expenses incurred by the Insured Person for Therapeutic Counseling sessions up to the Therapeutic Counseling Benefit Amount per session for the Maximum Number of Sessions as shown in the Rider Schedule below, if:

1) an Insured Person incurs a Covered Loss, other than a loss of life, for which a benefit is payable under the Accidental Dismemberment or Paralysis Benefits of the Policy; and

2) the Insured Person initially requires Therapeutic Counseling within 365 days due to the Covered Loss.

Benefits for any Therapeutic Counseling session must be incurred within 2 year(s) after the date of the Covered Accident causing the Injury.

RIDER SCHEDULE

Therapeutic Counseling Benefit

Class:	Benefit Amount:	Maximum Number of Sessions:
Class 1, 2, 3, 4, 5	$250 per session	20

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, evidence of expenses incurred for services provided for Therapeutic Counseling is required in order to receive benefits under this Rider.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist, counselor, or psychiatrist who is registered or certified to provide psychological treatment or counseling.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-60 — Worksite Modification Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

WORKSITE MODIFICATION BENEFIT

If an Insured Person suffers an Injury, other than loss of life, that results in a loss payable under the Accidental Dismemberment, or Paralysis Benefit, We will pay an additional benefit that is the lesser of:

1) the Benefit Amount as indicated in the Rider Schedule; or
2) the actual cost for the Covered Worksite Modification Expenses that are incurred within 12 months of the date of the Covered Accident that caused the Injury if an Insured Person:
   a) did not require, prior to the date of the Accident that caused the Injury, the use of a wheelchair or other adaptive device to be ambulatory; and
   b) as a direct result of such Injury, the use of a wheelchair or other adaptive device to be ambulatory is now compulsory.

RIDER SCHEDULE

Worksite Modification Benefit

Class:	Benefit Amount:
Class 1, 2, 3, 4, 5	$25,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Worksite Modification Expenses for the purpose of this Rider, means one-time expenses that are charged for alterations to the Insured Person's work station that are necessary to make it accessible for a wheelchair-confined person or adaptive device user, but do not:

1) include charges that would not have been made if no insurance existed; and
2) exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred; but only if the alterations to the Insured Person's worksite are:
   a) made on behalf of the Insured Person;
   b) recommended by a nationally-recognized organization providing support and assistance to wheelchair or other adaptive device users;
   c) carried out by individuals experienced in such alterations and modifications; and
   d) in compliance with any applicable laws or requirements for approval by the appropriate government authorities.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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