Sprint Basic Medical Plan

Coverage Information Section of the Summary Plan Description

(Administered by Blue Cross Blue Shield of Illinois)

2016 Plan Year

What is Inside

This Coverage Information Section of the Summary Plan Description (SPD) for your Sprint Basic Medical Plan (Plan or Basic Plan) has been created using simple terms in an easy-to-understand format.

This Section will use the terms "we," "our" or "us" to refer to Sprint and to "you" or "your" to refer to eligible persons properly enrolled in this Plan.

Sprint intends to continue the Plan. However, we reserve the right to change or discontinue the Plan at any time.

In case of any conflict with this SPD, the Sprint Welfare Benefits Plan for Employees will control.

Please be sure to read through this entire Medical Plan SPD Coverage Information Section for details and important information.

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Introduction to Your Basic Plan

The Sprint Basic Plan is a "high deductible health plan" allowing you to be eligible to contribute, and receive additional Sprint-funded health care dollars, to a "Health Savings Account" (HSA) and the freedom to make choices that align with your needs and values. It provides a unique approach to pay for preventive care and a safety net of some coverage for major health care expenses.

The Sprint Basic Plan:

- lets you choose your Provider (no referrals required);
- provides higher Benefits for Network Providers;
- pays Benefits after you've met the Deductible;
- covers qualifying Preventive Services from a Network Provider at 100%;
- includes coverage for Prescription Drugs; and
- offers health resources that help you take greater control over your and your family's health care decisions.

The Plan provides Benefits in the form of reimbursement or direct payment of certain of your and your Covered Dependent's health care expenses. Which of your health care expenses and how much of them are paid or reimbursed by the Plan depends on many factors as described in this SPD.

For information on a Health Savings Account, including available Sprint funding to it, see i-Connect > Life and Career > Benefits Plan Information > Benefits Overview.

Plan Administration

The Plan Administrator has designated a Claims Administrator to receive, process, and administer benefit claims according to Plan provisions and to disburse claim payments and payment information. The Claims Administrators are:

- Blue Cross Blue Shield of Illinois (BCBS) for all Benefits except Prescription Drug Benefits
- CVSCaremark, LLC (CVS Caremark) for Prescription Drugs – Outpatient

BCBS
www.bcbsil.com/sprint
877-284-1571

CVS Caremark
www.caremark. com
855-848-9165

You will receive a Member ID card for each administrator: a "Medical Member ID card" and an "Rx Member ID card."

The Claims Administrators have established the Plan's Networks of Providers, negotiating contract rates for Services and Supplies, by reviewing Provider credentials, professional standards and accessibility in your community. To check the Network participation status of your current Providers, or for claims information, educational materials and more, visit the applicable Claims Administrator's website or call the number on the back of your applicable Member ID card.

Show your Member ID card whenever you visit your Provider. Your Member ID card contains important information, including the name of the Plan's Network. Carry your card at all times, and never lend it to anyone. If your Member ID card is lost or stolen, please contact the Claims Administrator.

Eligibility & Enrollment

For rules on who is eligible to be covered, enrollment, and effective dates of coverage in the Plan, see the separate *Eligibility & Enrollment* or *Life Events* Sections of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

How the Plan Works

Capitalized terms used in this document are defined here and in the Definitions section. Other capitalized terms are defined in other Sections of the SPD: *Eligibility and Enrollment, Life Events, and Legal Information.*

Following is the Plan's structure for payment of Benefits for Covered Health Expenses. Note: some components of this structure vary by "coverage tier" – i.e., whether your coverage is "Employee" only or "Family" (employee + family, employee plus children, or employee plus spouse/domestic partner).

Deductible

The Deductible is the amount of certain Covered Health Expenses that must be incurred in a calendar year before the Plan pays its portion of Coinsurance ("Deductible Expenses"). The Deductible Expenses include all Covered Health Expenses (i.e., not Excluded Health Care Expenses) except Preventive Prescription Drugs or Network Preventive Services or Supplies.

If you have employee-only coverage, the Plan begins paying Coinsurance as soon as your employee-only Deductible is met. If you have a family coverage tier, the Plan does not begin paying coverage for any covered family member until the family Deductible has been met (either through one covered family member's expenses or a combination of multiple covered family members' expenses).

The Deductible is as follows:

Coverage Tier	Network	Non-Network
Employee-only	$1,850	$3,700
Family	$3,700	$7,400

The Deductible is not prorated if your coverage becomes effective mid-year and is adjusted on a non-prorated basis to that for a new coverage category for mid-year Life Event changes.

The amounts applied toward your Deductible accumulate over the course of the calendar year as Claims Administrators process claims and apply toward both the Network and Non-Network, employee-only and family, Deductibles (except that Covered Expenses for Non-Network non-Preventive Prescription Drugs do not apply to the Non-Network Deductible).

Coinsurance

Your Coinsurance is the percentage of Covered Health Expenses (i.e., not Excluded Health Care Expenses), after any applicable Deductible is met, that you are responsible for, up to the Out-of-Pocket Limit. The Plan pays its Coinsurance, the remaining percentage of Covered Health Expenses, up to any specified Benefit Limits.

Except as noted in the *What is a Covered Health Service or Supply* section, the Coinsurance percentages of Covered Health Expenses depend on the kind of Services and Supplies and whether they are Network or Non-Network, as follows:

Provider/Service/Supply	Network		Non-Network	
	You Pay	Plan Pays	You Pay	Plan Pays
Preventive Services	0%	100%	100%*	0%*
Primary Care Providers	20%	80%	40%	60%
Facilities (except E.R.)	20%	80%	40%	60%
E.R. and Urgent Care for Emergency Services	20%	80%	20%	80%
E.R. for Non-Emergency Services	**40%**	**60%**	**40%**	**60%**
Prescription Drugs	20%	80%	40%	60%
Other Supplies	20%	80%	40%	60%

*You pay 40% and Plan Pays 60% for certain Non-Network Preventive Services as described in the *What is a Covered Health Service or Supply* section.

If you incur health care expenses exceeding the Covered Health Expenses, the amounts you pay are not considered Coinsurance and thus do not count toward your Deductible or Out-of-Pocket Limit.

Out-of-Pocket Limit

Once your Deductible Expenses and your portion of Coinsurance in a calendar year reach the applicable Out-of-Pocket Limit, the Plan pays 100% of Covered Health Expenses incurred in the rest of the calendar year, up to any specified Benefit Limits.

The amount of the Out-of-Pocket Limit is as follows:

Coverage Tier	Network	Non-Network
Employee-only	$4,000	$8,000
Family	$8,000*	$16,000

*The Plan contains an embedded individual out of pocket limit within the family network out of pocket limit, meaning that if one family member incurs network costs that exceed $6,850, the Plan will pay 100% of that family member’s remaining network expenses for the

calendar year, even if the aggregate out-of-pocket network expenses of all family members have not reached the cost-sharing limit for family coverage.

The Out-of-Pocket Limit is not prorated if your coverage becomes effective mid-year and is adjusted on a non-prorated basis to that for a new coverage category for mid-year Life Event changes.

If you are enrolled in a family tier, the family Out-of-Pocket Limit must be met before the Plan will begin to pay Benefits at 100% for any Member.

Your Deductible Expenses and your portion of Co-insurance apply toward both the Network employee-only and family Out-of-Pocket Limits and the Non-Network employee-only and family Out-of-Pocket Limit (except that Covered Expenses for Non-Network non-Preventive Prescription Drugs do not apply to the Non-Network Out-of-Pocket Limit).

The Network Difference

Network Coverage

The Sprint Basic Plan has a cost-saving national network of health care Providers, including Pharmacies.

The Network is an important feature of the Sprint Basic Plan because the billed charges from a Network Provider are often less than those from a Non-Network Provider. Also, the Plan generally pays higher Benefits for Network Covered Services and Supplies after the Deductible is met. Therefore, in most instances, your Out-of-Pocket expenses will be less if you use a Network Provider than if you use a Non-Network Provider. Plus, with Network Providers, there are no claim forms to file.

Provider Directory

You may view the Plan Network Provider directory, excluding Pharmacies, directory online at www.bcbsil.com/sprint or by calling BCBS at the toll-free number on your Medical Member ID card. You may view the Plan Network Pharmacy directory online at www.caremark.com or calling CVS Caremark at the toll-free number on your Member Rx ID Card.

When choosing a Provider, contact both the Provider and the Claims Administrator to confirm the Provider's current participation in the Network at the time of Service or Supply purchase.

Non-Network Coverage

Before you receive care from a Non-Network Provider, you may want to ask them about the Provider's billed charges and compare them to Allowable Amounts for those Services or Supplies. For Allowable Amounts, call the applicable Claims Administrator.

The Plan does give you the flexibility to use Non-Network Providers. If you choose Services or Supplies outside the Network, however:

- the Provider's charges may be more than the Allowable Amounts, sometimes significantly higher, which are **not Covered Health Expenses**;
- the Plan pays **no Benefit** for Preventive Services (except for Well Child Care through age 5 and certain Preventive Screenings for adults);

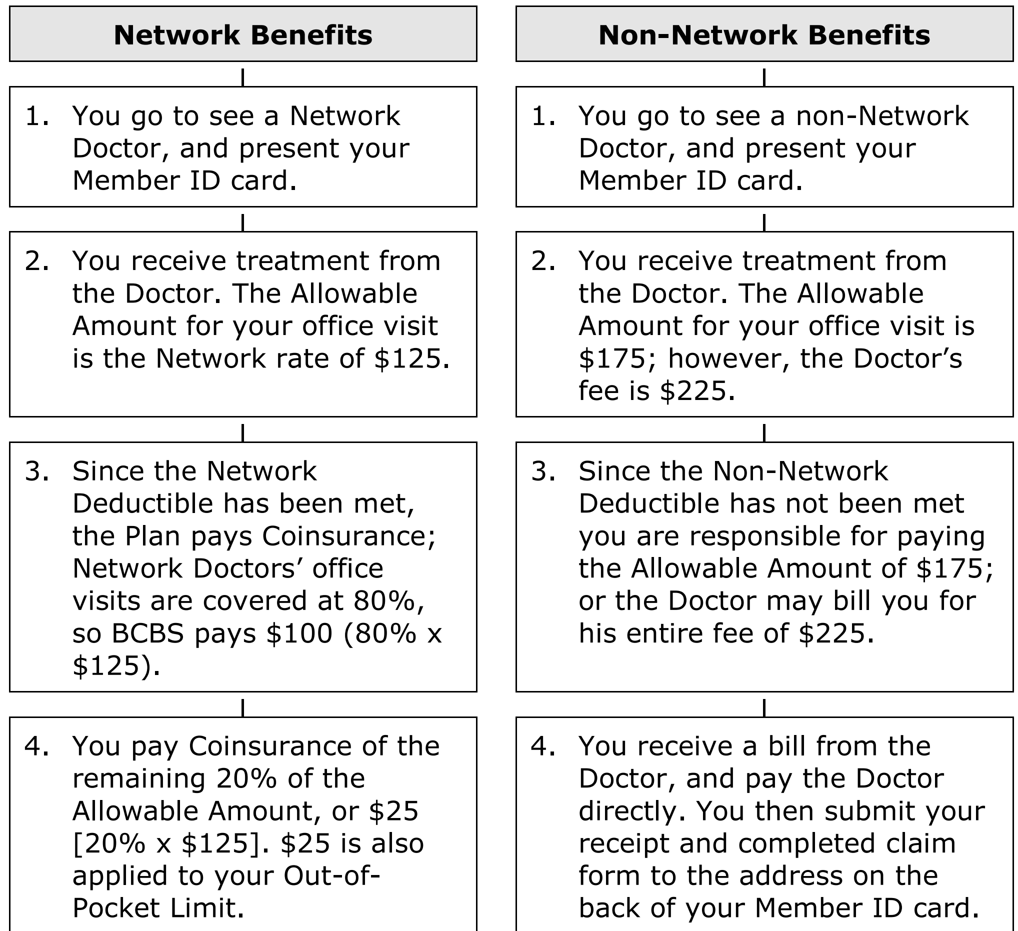
- you have to meet a **higher Deductible** (except for certain Preventive Services); and
- the Plan pays a **lower Benefit Level** after the Annual Non-Network Deductible and in some cases pays **no** Benefit Level.

Emergency Services received at a Non-Network facility, however, are covered at the Network Benefit Level.

Example

The following example illustrates how Deductibles, Coinsurance and Out-of-Pocket Limits vary depending on whether you use a Network or Non-Network Provider for a Covered Health Service.

Let's say you have employee-only coverage under the Plan: you have met your Network Deductible, but not your Non-Network Deductible, and need to see a Doctor. The flow chart below shows what happens when you visit a Network Provider versus a Non-Network Provider.



Network Benefits	Non-Network Benefits
1. You go to see a Network Doctor, and present your Member ID card.	1. You go to see a non-Network Doctor, and present your Member ID card.
2. You receive treatment from the Doctor. The Allowable Amount for your office visit is the Network rate of $125.	2. You receive treatment from the Doctor. The Allowable Amount for your office visit is $175; however, the Doctor’s fee is $225.
3. Since the Network Deductible has been met, the Plan pays Coinsurance; Network Doctors’ office visits are covered at 80%, so BCBS pays $100 (80% x $125).	3. Since the Non-Network Deductible has not been met you are responsible for paying the Allowable Amount of $175; or the Doctor may bill you for his entire fee of $225.
4. You pay Coinsurance of the remaining 20% of the Allowable Amount, or $25 [20% x $125]. $25 is also applied to your Out-of-Pocket Limit.	4. You receive a bill from the Doctor, and pay the Doctor directly. You then submit your receipt and completed claim form to the address on the back of your Member ID card.

5. $175 (Allowable Amount) is credited toward your Non-Network Deductible and Out-of-Pocket Limit; any remaining amount the Doctor billed and you paid (e.g., $50) does not get credited to either.

Coverage When Traveling

When you are away from home within the United States, your Plan coverage travels with you. Check with the Claims Administrator for the Network Provider Directory.

The Network does not extend internationally; however, Emergency Services and Supplies by Non-Network Providers, including international Providers, are covered at the Network level. Non-Emergency Services outside the United States are Excluded Health Services.

Covered Health Expenses

For purposes of Benefits payable or reimbursable under this Plan, Covered Health Expenses are charges by a Provider (who is not also the Patient) that are:

- directly related to **Covered Health Services and Supplies – not to Excluded Health Services or Supplies –** that:
  - are provided to a Member while properly enrolled in and covered under this Plan; and
  - meet all other requirements under the Plan as described in this Coverage Information Section; and
- **not Excluded Health Care Expenses**.

Excluded Health Care Expenses, which are not considered for purposes of the Deductible or Out-of-Pocket Limit, other Plan Benefits, are those charges**:**

The important thing to remember is that Network Providers may not charge more than the *Allowable Amounts* because of their agreement to be in the Network.

- **greater than the *Allowable Amount*** or Plan Benefit Limits (including the DAW, Step Therapy or 90-Day Fill Penalties – see Prescription Drugs - Outpatient);
- that would not ordinarily be made in the absence of coverage by this Plan;
- for missed appointments; room or facility reservations; completion of claim forms; record processing; or Services or Supplies that are advertised by the Provider as free;
- prohibited by anti-kickback or self-referral statutes;
- which the Patient is not legally required to pay, including charges paid or payable by the local, state or federal government (for example Medicare), whether or not payment or benefits are received, except as provided in this SPD (e.g., see the *Medicare and this Plan* section); and

- Services that are not coordinated through a Network Provider or Pharmacy if the Claims Administrator has determined that you were using health care Services or Prescription Drugs in a harmful or abusive manner (which Network Provider or Pharmacy you may select within 31 days of being notified by the Claims Administrator to do so or which otherwise the Claims Administrator will select for you).

What Is a Covered Health Service or Supply?

Definition

Covered Health Services and Supplies are Services and Supplies, which, subject to the rest of this section, are:

- rendered **by or pursuant to and consistent with** the directions, orders or prescription of a Doctor or Dentist and, except as noted below, in a facility that is **appropriate** for the Service or Supply and the Patient's Illness or Injury**;**
- **Medically Necessary** (including Preventive Services as noted); and
- **not Excluded Health Services and Supplies.**

Examples of Supplies or Services that *could* be Covered, subject to Specific Limits, Criteria and Exclusions below, are:

- Provider consultations (including second or third opinions) and exams, screenings (e.g., vision, hearing), and other diagnostics (lab, x-rays, imaging, biopsies, scopic procedures (such as arthroscopy, laparoscopy, bronchoscopy and hysteroscopy), cultures, etc.) in Provider's office, Hospital or Alternate Facility;
- Local and air ambulance and treatment at a Hospital Emergency Room or Alternate Facility, including an Urgent Care Center;
- Injections, chemo/radio therapy, dialysis, acupuncture, chiropractic and other therapeutic treatments;
- Surgeries at a Hospital or Alternate Facility, inpatient or outpatient, including:
  - pre- and post-operative care and related Doctor Services and Supplies (radiology, pathology and anesthesiology); and
  - room and board for Inpatient care and related facility Services and Supplies;
- Prescription Drugs;
- External Prostheses and other Durable Medical Equipment and certain Disposable Supplies; and
- Skilled Nursing and Rehabilitation Services, including physical, occupational, speech, and cognitive therapies, osteopathic manipulation, pulmonary rehabilitation and cardiac rehabilitation; and
- Home Health Care, Private Duty Nursing, and Hospice Care Services.

Sprint 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.

Prior Authorization

It is strongly recommended that you seek Pre-Authorization for certain health care Services and Supplies, including but not limited to the following:

- *All Non-Network Services and Supplies*, including but not limited to Home Health Care, Hospice Care, Private Duty Nursing, Mental Health Services, Reconstructive Services and Prosthetic Devices; and
- *Cancer, Transplant, Bariatric or Reconstructive Services and Supplies,* whether Network or Non-Network.

For All Pre-Authorizations Call…	
MEDICAL (BCBS)	PRESCRIPTION DRUG (CVS Caremark)
877-284-1571 7 a.m. - 6 p.m. CST Monday – Friday www.bcbsil.com/sprint	866-814-5506(24/7) www.caremark.com

In most cases your Provider will take care of obtaining Pre-authorization; however, **it is recommended that you be sure that pre-authorization has been requested and received.**

After receiving a pre-authorization request, using established medical guidelines, the Claims Administrator will determine the Medical Necessity of an Admission (including its length), other Service or Supply and whether other Limits, Criteria or Exclusions apply.

Specific Limits, Criteria and Exclusions

Following are, for certain Medical Conditions and Services or Supplies:

- specific **criteria** that must be met for certain Services or Supplies to be Covered;
- **specifically excluded** Services or Supplies, regardless of otherwise meeting the definition of Covered Health Services and Supplies; and
- specific **Benefit Limits** for certain Medical Conditions or Services or Supplies.

Please refer back to the Coinsurance section beginning on page 3 for the Plan's Benefit Level – **after the Deductible, except as noted** – for Covered Health Expenses, subject to any Benefit Limits stated in this section.

Please keep in mind that Medical Necessity is paramount in the Claims Administrator's determination of whether any of the following Services or Supplies is Covered.

Acupuncture & Chiropractic Services

Benefit Limit:
15 visits per calendar year Network and Non-Network combined, for all Services combined

Criteria for Coverage:

- Services must be performed in an office setting by a Doctor or an acupuncturist/chiropractor, as applicable, practicing within the scope of his/her license or certification.
- Services must be therapeutic and more than to maintain a level of functioning or prevent a Medical Condition from occurring or recurring.

Alternative Care

Benefit Limit:
15 visits per calendar year Network and Non-Network combined, for all Services combined

Coverage includes naturopathy, homeopathy, Chinese medicine, herbal supplements and herbal remedies. No diagnosis required but must be administered through a licensed provider. Benefits are not covered for acupressure, massage therapy and vitamins. Acupuncture services provided through alternative care will be applied to the separate Acupuncture & Chiropractic Services visit limit.

Ambulance

Criteria for Coverage of Local Ambulance: Must be:

- for Emergency only, except
  - from a Non-Network Hospital or Alternate Facility to a Network Hospital,
  - to a Hospital that provides a higher level of care,
  - to a more cost-effective acute care facility, or
  - from an acute care facility to a sub-acute setting; and
- by a licensed ambulance service and to the nearest Hospital that offers Emergency Services.

Criteria for Coverage of Air Ambulance:

- must be for Emergency only;
- ground transportation must be impossible or would put Member's life or health in serious jeopardy; and
- must be to the nearest (in the absence of special circumstances as approved by BCBS) facility where the needed medical Emergency Services can be provided.

Bariatric Surgery

Benefit Limit:

Bariatric Surgery may be considered not Medically Necessary or it may be considered Cosmetic. Pre-Authorization is strongly recommended.

Network only – 50% Coinsurance
Non-Network – **0%**

Criteria for Coverage:

- You are at least 21 years of age and have a minimum Body Mass Index (BMI) (a measurement of body fat) of 40, or 35 with complicating co-morbidities (such as sleep apnea or diabetes), directly related to or exacerbated by your obesity;
- You have documentation from a Doctor of a diagnosis of morbid obesity for a minimum of two years;
- You have documentation of participation in a weight loss program for the past six months reflecting attempted weight loss without successful long- term weight reductions;
- You have completed an evaluation by a licensed professional counselor, psychologist or psychiatrist within the six months preceding the request for surgery that documents:
  - the absence of significant psychopathology that would hinder your ability to understand the procedure and comply with medical/surgical recommendations,
  - any psychological co-morbidity that could contribute to weight mismanagement or a diagnosed eating disorder, and
  - your willingness to comply with preoperative and postoperative treatment plans;
- You meet either a Doctor-supervised nutrition and exercise program or a multi-disciplinary surgical preparatory regimen; and
- Your Services are performed at a COE if available within 150 miles of Patient's permanent residence.

Chiropractic Services – see Acupuncture & Chiropractic Services

Dental Services – Generally Excluded

The Exclusion for Dental care is broad: examples include treatment of congenitally missing, mal-positioned, or extra teeth, and treatment of dental caries resulting from dry mouth after radiation or as a result of medication. See your Dental plan for possible coverage.

Dental Services and Supplies are excluded, even if Medically Necessary, except as described below.

Accidental Injury

Covers only, except as included under Reconstructive Services, the following Dental Services and Supplies for and directly related to damage to a sound, natural tooth resulting from to Accidental Injury (i.e., not as a result of normal activities of daily living or extraordinary use of the teeth): Emergency examination, diagnostics, endodontics, temporary splinting of teeth, prefabricated post and core, simple minimal restorative procedures (fillings), extractions, post-traumatic crowns if the only clinically acceptable treatment, replacement of teeth lost due to the Accidental Injury by implant, dentures or bridges (but excluding repairs to bridges and crowns).

Criteria for Coverage:

- the Dentist certifies that the damaged tooth was virgin and unrestored and that it:
  - had no decay;
  - had no filling on more than two surfaces;
  - had no gum disease associated with bone loss;
  - had no root canal therapy; and

  - functioned normally in chewing and speech;
- initial contact with a Doctor or Dentist regarding damage occurred within 72 hours (or later as extended by and upon request to BCBS) of the Accidental Injury;
- Services for final treatment to repair the damage are started within three months (or later as extended by and upon request to BCBS) and completed within 12 months of the Injury; and
- Services are received from a Dentist (or Doctor as needed for Emergency treatment).

General Anesthesia

Covers general anesthesia Services and Supplies administered at a Hospital or Alternate Facility for Dental Services.

Criteria for Coverage
- The Patient is under age seven; or
- The Patient has a medical condition severely disabling him or her from having dental procedures safely performed without sedation under general anesthesia, regardless of age, as certified by a Doctor; or
- The Patient's health is compromised and general anesthesia is Medically Necessary, regardless of age.

Limited Medical Conditions

Covers only except as included under Reconstructive Services, diagnostic, restorative (basic and major restorative), endodontic, periodontic, and prosthodontic Services (1) for cancer or cleft palate; and (2) related to transplant preparation and use of immunosuppressives (does not include prosthodontics).

Includes excision of lesions or tumors, unless for removal of tori, exostoses, fibrous tuberosity (such as preparation for dentures) or for periodontal abscess, or endodontic cyst.

Disposable Medical Supplies

Covers only Supplies that are:
- provided incident to Services in a Hospital or Alternate Facility or Home Health Care;
- used in conjunction with Durable Medical Equipment (such as oxygen, tubings nasal cannulas, connectors and masks); or
- the following ostomy supplies: pouches, face plates, belts, irrigation sleeves, bags and catheters, and skin barriers.

Excludes: artificial aids including but not limited to elastic or compression stockings, garter belts, corsets, ace bandages, urinary catheters, and diabetic supplies covered as a Prescription Drug (such as blood glucose monitors, insulin syringes and needles, test strips, tablets and lancets), deodorants, filters lubricants, appliance cleaners, tape, adhesive, tape or adhesive remover and any other Disposable Medical Supply not specifically listed as included above.

Durable Medical Equipment (DME)

Benefit Limit:
One speech aid device and tracheo-esophageal voice device Lifetime Maximum.

Covers only:
- the most cost-effective alternative piece of one single unit of DME to meet your functional needs (example: one insulin pump);
- repairs if required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device;
- replacement of essential accessories, such as hoses, tubes, mouth pieces, etc.; and
- replacement only for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or due to a change in your Medical Condition.

Excludes repairs or replacement if lost or stolen or damaged due to misuse, malicious breakage or gross neglect.

Criteria for Coverage: DME must be ordered or provided by a Doctor for Outpatient use.

Emergency Room Services

"Emergency" is defined in the Definitions section. **Use of Emergency Room Services for a Non-Emergency results in Non-Network Coinsurance Level Plan Benefits, even at a Network facility.**

Family Planning Services

Excludes tubal ligation and vasectomy reversals.

Gender Identity Disorder Treatment

Benefit Limits:
Network only - 50%
$75,000 per Member Lifetime Maximum
Non-Network – **0%**

Includes psychotherapy, continuous hormone replacement (not oral - see *Prescription Drug Details* section) (including laboratory testing to monitor safety), Genital Surgery, Surgery to Change Secondary Sex Characteristics.

Rhinoplasty and blepharoplasty are generally considered Cosmetic or Not Medically Necessary.

Excludes:
- reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
- sperm preservation in advance of hormone treatment or gender surgery;
- cryopreservation of fertilized embryos.
- voice modification surgery;
- facial feminization surgery, including but not limited to: facial bone reduction, face "lift", facial hair removal, and certain facial plastic procedures;

- suction-assisted lipoplasty of the waist;
- drugs for hair loss or growth;
- drugs for sexual performance or Cosmetic purposes (except for hormone therapy described above);
- voice therapy; and
- transportation, meals, lodging or similar expenses.

Coverage for treatment of negative side effects of continuous hormone replacement depends solely on whether the treatment otherwise meets the Plan's coverage requirements.

Criteria for Coverage of Continuous Hormone Replacement. In order to receive hormones (not oral – see *Prescription Drug* Section) of the desired gender, the Member must:

- have a diagnosed Gender Identity Disorder;
- be at least age 18;
- demonstrate knowledge of what hormones medically can and cannot do and their social benefits and risks; and
- have already had completed:
    - a documented real-life experience living as the desired gender of at least three months; and
    - a period of psychotherapy of a duration specified by the Mental Health Professional after the initial evaluation (usually a minimum of three months).

Gender Identity Disorder means a disorder characterized by the following diagnostic criteria:

- a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex);
- the member's persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex;
- the disturbance is not concurrent with a physical intersex condition; and
- the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criteria for Coverage of Surgery. In order to receive Genital Surgery or Surgery to Change Secondary Sex Characteristics:

- the Member must have a diagnosed Gender Identity Disorder;
- the Surgery must be performed by a Provider at a Hospital or Alternate Facility with a history of treating persons with Gender Identity Disorder;
- the treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH, an advocacy group) standards;
- the Member must be at least age 18 years or older for irreversible surgical interventions;
- the Member must complete 12 months of Continuous Hormone Therapy for those without contraindications; and
- the Member must complete 12 months of successful continuous full time real life experience in the desired gender.

Genital Surgery means one of the following: complete hysterectomy, orchiectomy, penectomy, vaginoplasty, vaginectomy, clitoroplasty, labiaplasty, salpingo-oophorectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prosthesis, phalloplasty.

Genetic Services

Covers only a proven testing method for identification of genetically-linked inheritable disease and genetic counseling.

Criteria for coverage generally:
- the Member has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Criteria for coverage of embryo genetic testing prior to implantation: Either donor has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.
Criteria for coverage of genetic counseling: Member must be undergoing approved genetic testing or have an inherited disease and is a potential candidate for genetic testing.

Hearing Care Services and Supplies

Benefit Limits:
Network – hearing aids (electronic amplifying devices designed to bring sound more effectively into the ear consisting of a microphone, amplifier and receiver): 50% for left and/or right ears every 2 years.
Non-Network – Exam and fitting of hearing aids **only.**

Covers only;
- routine hearing screenings;
- routine hearing exams when associated with an evaluation for a hearing aid by a Provider in the Provider's office;
- hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound that may range from slight to complete deafness) and associated fitting and testing; and
- cochlear implant or bone anchored implant (subject to below) and Surgery to implant.

Criteria for coverage:
- Hearing aid and implant covers only as described under Durable Medical Equipment.
- For bone anchored implants: You must have either of the following:
  - craniofacial anomalies and abnormal or absent ear canals that preclude the use of a wearable hearing aid; or
  - hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Home Health Care Services

With Home Health Care, you can recuperate in the comfort of your home as an alternative to prolonged Hospital confinement.

Benefit Limits:
Non-Network – 60 visits (of any duration) per calendar year

Criteria for coverage: Must be:
- ordered and supervised by a Physician;
- when Skilled Care is required either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less; and

- provided in your home by a Registered Nurse, or by either a home health aide or Licensed Practical Nurse and supervised by a Registered Nurse.

Hospice Care

Benefit Limits:
After Member's death, only 3 counseling sessions, for up to 12 months.

Criteria for Coverage:

- Member must be diagnosed with terminal Illness (expected to live six or less months), as certified by an Attending Doctor who recommended the Hospice Care;
- Hospice Care must be received from a licensed hospice agency, which can include a Hospital; and
- Except for post-death bereavement, charges must be incurred within six months after the certification or recertification (required if Member still living after six months from prior certification) of terminal Illness.

Infertility Services

Benefit Limit:
Network – $7,500 Lifetime Maximum for non-Prescription Drug Services and Supplies, including all Assisted Reproductive Technology and Ovulation induction (also see Prescription Drugs – Outpatient).

Non-Network – **0%** except for diagnosis and treatment of underlying medical condition.

Criteria for Coverage: Services must be performed at Doctor's office, Hospital or Alternate Facility.

Includes ovulation induction with ovulatory stimulant drugs, artificial insemination, in vitro fertilization (IVF), Zygote intra-fallopian transfer (ZIFT), Gamete intra-fallopian transfer (GIFT), embryo transport, intracytoplasmic sperm injection (ICSI), ovum microsurgery, donor ovum and semen and related costs, including collection, preparation and storage.

Excludes:

- purchase of donor sperm;
- care of donor egg retrievals or transfers;
- cyropreservation or storage of cryopreserved embryos and thawing;
- Prescription Drugs including injectable infertility medications (see Prescription Drugs - Outpatient);
- home ovulation predictor kits; and
- Gestational carrier programs.

Criteria for Coverage of Assisted Reproductive Technology for female Member:

- there must exist a condition that:
  - is a demonstrated cause of infertility, has been recognized by a gynecologist or infertility specialist, and is not caused by voluntary sterilization or a hysterectomy with or without surgical reversal;
  - a female under age 35 has not been able to conceive after one year or more without contraception or 12 cycles of artificial partner or donor insemination; or
  - a female age 35 or older has not been able to conceive after six months without contraception or six cycles of artificial partner or donor insemination;
- the procedures are performed while not confined in a Hospital or Alternate Facility as an inpatient;
- ***FSH levels are less than or equal to 19 miU on day three of the menstrual cycle; and***
- pregnancy cannot be attained through less costly treatments for which coverage is available under the Plan.

Inpatient Stay

For all Inpatient Stays, covers only up to cost of semi-private room, unless no semi-private rooms are available or if a private room is necessary according to generally accepted medical practice.

Maternity Services

Expectant mothers are asked to call **Sprint Alive! at 866-90-ALIVE (25483) before the end of their first trimester.**

Includes:
- prenatal care, delivery, postnatal care and any related complications;
- midwife visit to confirm pregnancy and all subsequent visits; and
- Inpatient Stays for mother and newborn in Hospital or Network birthing center of up to 48 hours following vaginal delivery and up to 96 hours following cesarean section delivery.;

Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus generally not considered Medically Necessary except to determine the existence of a sex-linked genetic disorder.

Any Inpatient Stay for the baby longer than the mother's is subject to the baby being a **Covered Dependent** under the Plan – see *Eligibility and Enrollment Section* of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions) – and a **separate Deductible** and **Coinsurance**.

Remember, you must notify the EHL (ehlticket or 800-697-6000) within 30 calendar days after the birth to add your newborn as a Covered Dependent.

Excludes home birthing or doula Services or Supplies.

Mental Health/Substance Use Disorder Services

Includes inpatient (Hospital or Alternate Facility) and outpatient (Provider's office or Alternate Facility):

- diagnostic evaluations and assessment;
- treatment planning;
- referral Services;
- medication management and other psychiatric Services;
- individual, family, therapeutic group and Provider-based case management Services and therapy;
- crisis intervention;
- detoxification (sub-acute/non-medical); and
- Transitional Care.

Transitional Care means Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, 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 Patient with recovery.
- supervised living arrangements that are residences such as transitional living facilities, group homes and supervised apartments that provide Members with stable and safe housing and the opportunity to learn how to manage their 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 Patient with recovery.

<u>Excludes</u>:

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Services or Supplies for the diagnosis or treatment of Mental Illness, or Substance Use Disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are not:
  - consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
  - clinically appropriate for the Patient's Mental Illness/Substance Use Disorder based on generally accepted standards of medical practice and benchmarks;
- Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

- Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
- Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and
- intensive behavioral therapies such as applied behavioral analysis for 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)*.

Criteria for Coverage:

- Services must be coordinated, authorized and overseen by BCBS's Mental Health/Substance Use Disorder Administrator:
- Semi-private room only.

Criteria for coverage of psychiatric Services for Autism Spectrum Disorders: Services must be 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 property and impairment in daily functioning.

Criteria for Coverage of Special Programs:
Special programs for the treatment of your Substance Use Disorder that may not otherwise be covered under this Plan require referral to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Member and is not mandatory.

Nutrition Services and Supplies

Covers only (1) an individual session with a registered dietician and (2) enteral feedings and other nutritional and electrolyte formulas, including infant formula (except available over the counter) and donor breast milk that are the only source of nutrition or are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).

Criteria for Coverage for counseling:
Member must have an Illness that requires a special diet, such as, diabetes mellitus, coronary artery disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria (a genetic disorder diagnosed at infancy), and hyperlipidemia (excess of fatty substance use disorders in the blood).

Excludes:

- all other individual or group nutritional counseling;

- nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition therapy;
- food of any kind except as noted above; and
- health education classes unless offered by BCBS, such as asthma, smoking cessation and weight control classes.

Organ or Tissue Transplant Services

Benefit Limit: Non-Network **– 0%**

Examples include autologous bone marrow/stem cell, cornea, heart, lung, kidney, pancreas, liver.

Some transplants might be considered Cosmetic/not Medically Necessary or Experimental or Investigational, such as hair transplants. Pre-Authorization is recommended.

Includes:
- compatibility testing undertaken prior to procurement;
- obtaining the organ and tissue (removing, preserving and transporting the donated part);
- Hospitalization and Surgery for live donor;
- rental of wheelchairs, hospital-type beds and mechanical equipment required to treat respiratory impairment.

Criteria for Coverage:
- Services must be ordered by a Network Provider; and
- except for cornea transplants, Services must be performed at a COE if available within 150 miles of Patient's permanent residence, or a Network facility if there is no COE available within 150 miles of the Patient's permanent residence.

Pharmaceutical Products

Covers: Pharmaceutical Products not typically available by prescription at a pharmacy, and their administration, including:
- allergy immunotherapy, oncology (radiation or intravenous chemotherapy) and rheumatology;
- antibiotics; and
- inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Criteria for Coverage:
Must be administered or supervised by Doctor within the scope of the provider's license **on an outpatient basis only** in a Hospital, Alternate Facility, Doctor's office or in the Patient's home.

Podiatry Services and Supplies

Routine Foot Care for the treatment of diabetes or peripheral vascular disease may be Medically Necessary, but other Routine Foot Care seldom is Medically Necessary.

Also, foot orthotics such as arch supports, inserts or additions and orthopedic shoes are usually considered **Cosmetic, and thus, are Excluded Supplies,** but may be Medically Necessary for certain Medical Conditions such as, but not limited to, diabetes.

Routine Foot Care includes cleaning and soaking of feet and the application of skin creams (unless foot-localized Illness or Injury or in the case of risk of neurological or vascular disease arising from diseases such as diabetes); nail trimming and cutting, debriding (removal of dead skin or underlying tissue); treatment of toe nail fungus, flat and subluxation of feet, superficial lesions of the feet, such as corns, callouses and hyperkeratosis; arch supports, shoe inserts, shoes, lifts, wedges, and orthotics.

Prescription Drugs – Outpatient

Access a complete list of Specialty Prescription Drugs at www.caremark.com or call the number on the back of your Rx Member ID card. Contact CVS Caremark to enroll in the CVS Caremark **Specialty Program** of expert therapy management services.

Find a list of Maintenance Drugs at www.caremark.com. For Maintenance Drugs, ask your Doctor to write your prescription for a 90-day supply, not a 30-day supply with two refills.

This section applies to non-Preventive Prescription Drugs for Outpatient use.

- Prescription Drugs would be covered as any other Supply in the course of an Inpatient Stay.
- The Allowable Amount of **Preventive Drugs** is a Covered Health Expense but is not subject to the Deductible.

Subject to the below Benefit Limits and up to applicable Supply Limits, the Allowable Amount of **Prescription Drugs on the PDL** (unless Excluded below) that are dispensed by a Pharmacy pursuant to a Doctor's Prescription is a Covered Health Expense.

Benefit Limits
The following are **Excluded Health Care Expenses**:

- "DAW Penalty:
  - Allowable Amount of a Tier 2 or Tier 3 multi-source drug less the Allowable Amount of available generic Therapeutically Equivalent Prescription Drug, unless you receive prior approval from CVS.
  - Your Co-insurance, as applied to the Allowable Amount of the Tier 2 or Tier 3 multi-source drug (but not more than, when added to the DAW Penalty, the cost of the Tier 2 or Tier 3 multi-source drug).
- Full Allowable Amount of Specialty Drugs (defined below), unless dispensed through CVS Caremark Specialty Program.
- Full Allowable Amount of Maintenance Drugs (defined below) for less than a 90-day supply through Mail Order Service or Retail 90 Pharmacies (except for initial 30-day supply and one 30-day refill), where allowed by law.
- Full Allowable Amount of Step Therapy Drugs (defined below), unless you first used a generic Prescription Drug (or "first-line therapy") for 30 days before use of the higher tier Step Therapy Drug.

Excluded:

- oral non-sedating antihistamines or a combination of antihistamines and decongestants;
- anti-ulcer medications in the Proton-Pump Inhibitor (PPI) therapeutic class;
- erectile dysfunction drugs;
- Prescription Drugs that:
  - are available, or are comprised of components that are available, in a Therapeutically Equivalent over-the-counter form (except as specifically included above);

- replace a Prescription Drug that was lost, stolen, broken or destroyed; or
  - are provided following a Member's Medicare-eligibility; and
- vitamins, minerals, and food, dietary and nutritional supplements, except (1) Preventive Drugs, and (2) prenatal vitamins, vitamins with fluoride, and single entity vitamins pursuant to a prescription, or prescribed to maintain sufficient nutrients to maintain weight and strength equal to the Patient's overall health status.

Definitions

Doctor's Prescription means a prescription by a Doctor that:

- specifies number of refills,
- is limited to number of refills under accepted medical practice standards and
- is less than one year old at the time of dispensing unless otherwise permitted by applicable law.

Supply Limit means CVS Caremark's restriction on the amount of a Prescription Drug dispensed per prescription order or refill as found at www.sprint.com/benefits.

DAW means "Dispense as Written;" i.e., your or your Doctor's instruction to not allow substitution of a generic or preferred Therapeutically Equivalent Prescription Drug for the prescribed branded or non-preferred Prescription Drug.

Specialty Drug means Prescription Drug that is generally high cost drug that requires close clinical monitoring and customized medication management, may require special handling or administration, may be produced by biological processes, and are used to diagnose or treat patients with chronic, rare or complex Medical Conditions.

Maintenance Drug means a maintenance medication to treat certain Medical Conditions such as diabetes, glaucoma, blood pressure/heart disease, high cholesterol and hormone deficiencies.

Step Therapy Drug means single-source Tier 1 or 2 drugs including ACE inhibitors, benign prostatic hyperplasia (BPH) treatment, oral bisphosphonates, COX-2 inhibitors, DPP-4 Inhibitors, leukotriene inhibitors, long acting β-agonists (LABA), pregabalin, selective serotonin reuptake inhibitors (SSRIs), statins and atomoxetine.

Diabetic Supplies means insulin syringes with needles; blood testing strips - glucose; urine testing strips - glucose; ketone testing strips and tablets; lancets and lancet devices; insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and glucose monitors.

Therapeutically Equivalent means having essentially the same efficacy and adverse effect profile.

Preventive Services

Network Benefit: 100%

See the Definitions Section for the list of all Preventive Services.

Benefit Limit:
Non-Network – **0%**, except for only:

- prostate exam for males age 40 and over (once a year);
- breast cancer screening with mammography – with or without clinical breast examination, every 1-2 years for women age 40 years and older;
- pap smear (but not routine exam);
- colorectal screening for average risk males and/or females age 50 and over, which includes:
  - colonoscopy (covered every 10 years);
  - Double Contrast Barium Enema –DCBE (every 5 years); and
  - sigmoidoscopy (every 5 years);
- cardiovascular/cholesterol screenings (for age 20 and above; every 5 years);
- osteoporosis (for women age 65 or older or for women at age 60 that are high risk); and
- well child services:
  - circumcision, medical examinations and tests, and immunizations through age five; and
  - eight exams during the first 18 months of the baby's life and four exams through age five.

Private Duty Nursing

Covers only outpatient Private Duty Nursing care given on an outpatient basis only by a Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse.

Prosthetic Devices – see also Hearing Services and Supplies (for bone anchored implants)

Benefit Limits:
Network – Covers purchase, repair and replacement, including Non-Network Benefits, per device, once every two years.

Covers only:

- the most cost-effective alternative piece of one single device to meet your functional needs;
- repairs if required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device; and
- replacement only for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or due to a change in your Medical Condition.

Criteria for Coverage:

- Must be ordered or provided by a Doctor for Outpatient use.
- Must be following mastectomy for breast prosthesis.

Qualifying Clinical Trials

Covers: Routine Patient Costs.

Radiotherapy (e.g., radiation) – see Pharmaceutical Products

Reconstructive Services

Includes: breast reconstruction following a mastectomy, reconstruction of the non-affected breast to achieve symmetry and replacement of existing breast implant if initial breast implant followed mastectomy and other Services and Supplies required by the Women's Health and Cancer Rights Act of 1998, such as treatment of complications.

Criteria for Coverage: Patient has a physical impairment and the primary purpose of the procedure is Reconstructive.

Criteria for Coverage of Orthognathic Surgery: must be for the treatment of:

- maxillary and/or mandibular facial skeletal deformities associated with masticatory malocclusion (specific anteroposterior, vertical, transverse discrepancies and asymmetries), facial trauma, syndromes such as Apert or Crouzon, facial clefts, neoplasms, surgical resection, iatrogenic radiation; or
- facial skeletal anomaly of either the maxilla or mandible that demonstrates a functional medical impairment such as:
  - inability to incise solid foods;
  - choking on incompletely masticated solid foods;
  - damage to soft tissue during mastication;
  - malnutrition and weight loss due to inadequate intake secondary to the jaw deformity; or
  - documented speech impairment, sleep apnea, airway defects, soft tissue discrepancies or temporomandibular joint pathology.

Reconstructive means where the expected outcome is physiologic restoration or improvement of a physical impairment – i.e., the targeted body part is made to work better – not just relieving psychological suffering as a result of the impairment.

Rehabilitation Facility Services – see Skilled Nursing and Rehabilitation Facility Services – Outpatient

Rehabilitation Services

Benefit Limit:

- Maximum 60 visits/days per Member per calendar year for physical, occupational, cognitive and speech therapy combined.
- Maximum 30 visits/calendar year for Developmental Speech Therapy (up to age 7); not combined with other rehabilitation service limits.

Includes physical, occupational, speech, post-cochlear implant aural therapy, vision, cognitive following a post-traumatic brain injury or cerebral vascular accident, osteopathic, pulmonary and cardiac therapy.

Excludes:

- when part of authorized Home Health Care, except as provided under Home Health Care Services;

- at BCBS's discretion, Rehabilitation Services that are not expected to result in significant physical improvement in Member's condition within two months of the start of treatment or if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a Medical Condition from occurring or recurring.

Criteria for Coverage: Services must be provided by a licensed therapy Provider under the direction of a Doctor.

Criteria for Coverage of speech therapy: the speech impediment or dysfunction must have resulted from Injury, Illness, stroke or a Congenital Anomaly, is developmental in nature up to age 7, or is needed following the placement of a cochlear implant

Skilled Nursing and Rehabilitation Facility Services – Outpatient

Benefit Limit:
90-day Maximum per Member per calendar year Network/Non-Network combined (both Skilled Nursing and Rehabilitation)

Criteria for Coverage:
- Must be needed because:
  - the Medical Condition requires intensity of care less than that provided at a Hospital but greater than that available in a home setting; or
  - a combination of Skilled Nursing and Rehabilitation Services are needed on a daily basis or if Medical Condition would have otherwise required an Inpatient Stay in a Hospital; and
  - you are expected to improve to a predictable level of recovery.

Spinal Services – see Acupuncture & Chiropractic Service

Substance Use Disorder Services – see Mental Health/Substance Use Disorder Services

Temporomandibular Joint Dysfunction (TMJ) Services – see Reconstructive Services

Travel Expenses

Benefit Limit:
Network only
$50 per person daily limit per person, up to $100 total.
$10,000 Lifetime Maximum for organ transplant, bariatric and cancer services combined.
Non-Network **– 0%**

Includes transportation, meals purchased in the Hospital or Alternate Facility and lodging for Patient not covered by Medicare and one companion (two if Patient Member is minor child) for **only** bariatric, cancer and organ transplant Services.

Examples of Covered Travel Expenses include airfare at coach rate, taxi or ground transportation and mileage reimbursement at the IRS rate for the most direct route between Patient's residence and Facility.

Criteria for Coverage:
- Services for cancer and organ transplant must be received at a COE;

- facility must be more than 100 miles (most direct route) from Patient's permanent residence
- transportation expenses are limited to travel of the Patient and companion traveling on the same day(s) to and/or from the facility for the purposes of an evaluation, the procedure or necessary post-discharge follow-up; and
- BCBS must receive valid receipts for such charges.

Vision Care – Generally Excluded

Covers only:
- refractive eye care only if associated with a medical diagnosis such as diabetes;
- vision screenings part of an annual physical examination; and
- the first pair of contact/glass lenses as treatment of keratoconus or post cataract surgery and their fitting.

Excludes other vision care, such as routine eye exams and procedures performed for the purpose of correcting refractive disorders (including radial keratotomy), vision conditions such as nearsightedness (myopia), farsightedness (hyperopia), astigmatism and the need for reading glasses (presbyopia).

Well Child/Well Adult Care – see Preventive Services

Wigs

Benefit Limit: One per calendar year combined for Network and Non-Network

Covered only when there has been a loss of hair resulting from disease, treatment of disease or accidental Injury.

Additional Excluded Services and Supplies

In addition to those Services and Supplies noted as Excluded or limited in the previous section, the following Services or Supplies are Excluded Health Care Services and Supplies under this Plan, even if they are recommended or prescribed by a Provider or are the only available treatment for your condition. This means that no Plan Benefits are payable for expenses for the following general exclusions(unless they are specifically included in the prior section (e.g., wigs)):

Autopsies and other coroner services and transportation services for a corpse.
Chelation therapy, except to treat heavy metal poisoning.
Cosmetic Services and Supplies.
Custodial Services not intended primarily to treat a specific Medical Condition, or any education or training or Custodial Services provided by a personal care assistant or care in a nursing or convalescent home.
Diagnostic tests that are administered in other than a Doctor's office,

Hospital or Alternate Facility and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests.
Domiciliary Care, meaning living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.
Education therapy.
Experimental or Investigational Services and Supplies and Routine Patient Care costs incurred in connection with the receipt thereof, except for (1) Routine Patient Care costs incurred during participation in a Qualifying Clinical Trial if the patient is clinically eligible for such participation as defined by the researcher, or (2) a Prescription Drug on an Outpatient basis if the Claims Administrator determines that: the Medical Condition can be expected to cause death within one year of the request for, in the absence of, the Service/Supply; and the Service or Supply, although unproven, has significant potential as an effective treatment for the Medical Condition.
Services and Supplies received (1) for treatment of military service-related disabilities other coverage for which the Patient is legally entitled to at facilities that are reasonably available, whether or not payment or benefits are received; (2) for Services for which coverage is available while on active duty in the armed forces; (3) for a Medical Condition resulting from (a) war or any act of war, whether declared or undeclared, while the Patient is part of any armed service force of any country or (b) or in the course of, any employment for wage or profit, whether or not it is covered by Workers' Compensation or similar insurance.
Food, except meals that are covered Travel Expenses.
Growth hormone therapy.
Health club memberships and programs, and spa treatments.
Health education classes.
Health Services or Supplies provided or Prescription Drugs dispensed outside of the United States unless required for an Emergency.
Income taxes.
Immunizations for travel or work.
Medical and appliance or surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer) .
Personal Care, comfort or convenience items, including but not limited to: television, telephone, beauty/barber service, guest service, air conditioners, purifiers and filters, batteries and chargers, dehumidifiers and humidifiers, ergonomically correct chairs, non-Hospital beds, comfort beds, motorized beds and mattresses, car seats.
Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments: when required solely for purposes of

career, education, sports or camp, employment, insurance, marriage or adoption; as a result of incarceration; conducted for purposes of medical research; related to judicial or administrative proceedings or orders; or required to obtain or maintain a license of any type.
Respite care not associated with Hospice Care.
Rest cures.
Services performed at a diagnostic facility from a Provider affiliated with the facility that is not actively involved in your Medical care related to the Service.
Services or Supplies for sexual dysfunction including but not limited to erectile dysfunction.
Spinal treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies.
Storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery.
Therapy to improve general physical condition in the absence of a diagnosis or not Restorative in nature.
Third party requests including reports, evaluations, examinations, or hospitalizations not required for health reasons, such as: employment, insurance or government licenses and court ordered forensic or custodial evaluations.
Transportation, except as a covered Travel Expense.
Vocational rehabilitation or work hardening (individualized treatment programs designed to return a person to work or prepare a person for specific work.

Filing Claims

The following paragraphs explain when and how to file claims to your Plan for Covered Health Expenses.

Network Benefits

In general, if you receive Covered Health Services or Supplies from a Network Provider, including a Pharmacy, the Claims Administrator will pay the Provider directly. Keep in mind, you are responsible for paying Out-of-Pocket Expenses at the time of Service or when you receive a bill from the Provider. If a Network Provider bills you for any Covered Health Service or Supply other than for the amount of your Deductible or Co-insurance, please contact the Provider or call the Claims Administrator at the phone number on your Medical or Rx Member ID Card.

Non-Network Benefits

If you receive a bill for Covered Health Services or Supplies from a Non-Network Provider, you (or the Provider) must send the bill to the Claims Administrator for processing.

How to File a Claim

Obtain a medical coverage claim form from EHL (ehlticket or 800-697-6000) or from the Claims Administrator at the address, or number or website on the back of your Member ID card.

Read and follow the instructions on the claim form and mail your completed form along with any supporting documentation or itemized bills to the Claims Administrator. Include the group number for filing claims under the Plan. Be sure to keep copies of your claims for future reference.

Mail Claim Form and Supporting Documentation to…	
MEDICAL (BCBS)	PRESCRIPTION DRUG (CVS Caremark)
Blue Cross Blue Shield of Illinois P. O. Box 805107 Chicago, Illinois 60680-4112	CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136

Claim Filing Deadline

Claims for Covered Health Services or Supplies must be filed with the applicable Claims Administrator no later than two years following the date of the Service or Supply (one year following Prescription Drug dispense) in order to be considered for reimbursement. Claims submitted after the deadline will not be paid.

Payment of Benefits

After your claim has been processed, any Benefits will be paid to you unless:

- the Provider notifies the Claims Administrator that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make written requires for the non-Network Provider to be paid directly at the time you submit your claim.

The Claims Administrator will not pay to a third party, even if your Provider has assigned Benefits to that third party.

It is your responsibility to pay the Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Explanation of Benefits (EOB)

You may request that the Claims Administrator 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 Member

ID card to request them. You can also view and print all of your EOBs online at the applicable Claims Administrator's website.

Voluntary Resources – Making the Most of Sprint Benefits

BCBS Case Management

For Case Management Call…

877-284-1571
8 a.m. - 8 p.m.
(caller's local time)
Monday – Friday
Outside of these hours, you may leave a message and a representative will return your call. *This is a voluntary service.*

Case Management is a voluntary service offered by the Plan to assist you and your family in the event of a Member's catastrophic Illness or Injury — such as major head trauma, neonatal high-risk infants and multiple sclerosis. A BCBS case manager works with you and the Patient's Attending Doctor to design and coordinate a treatment plan that is comprehensive, practical and medically appropriate.

If you suffer such a major personal injury or develop a major illness, the Plan may pay benefits for Services and Supplies that exceed the Benefits that would be payable for such charges otherwise. For example, if your case manager recommends a Skilled Nursing Facility as an appropriate alternative for hospitalization, the Skilled Nursing Facility day Maximum may be waived.

To determine the amount payable, the following is considered:

- the Patient's medical status,
- the Patient's current treatment plan,
- the Patient's projected treatment plan,
- the long-term cost implications, and
- the effectiveness of care.

BCBS Condition Management Programs

Living every day with a chronic health condition can be difficult. As part of the Blue Care Connection® program and available at no additional cost, Blue Cross and Blue Shield of Illinois (BCBSIL) offers voluntary comprehensive Condition Management programs that can help you manage your medical condition and change unhealthy behaviors.

The Condition Management programs work together with you, your health plan and your doctor to help identify the best ways to manage your chronic health condition and stay healthy. When you enroll, you will have access to the best knowledge, tools and self-care techniques to help you make a difference in your health.

The Programs are available for the following conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes

To enroll in a Condition Management program, or to find out how one of the programs can help you, call BCBS at the number on the back of your ID card.

24/7 NurseLine

NurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call (800) 299-0274, a registered nurse may refer you to any additional resources that Sprint has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

When should you call?

The toll-free Nurseline can help you or a covered family member get answers to health problem questions, such as:

- Asthma, back pain or chronic health issues
- Dizziness or severe headaches
- High fever
- A baby's nonstop crying
- Cuts or burns
- Sore throat

Plus, when you call, you can access an audio library of more than 1,000 health topics—from allergies to women's health—with more than 600 topics available in Spanish.

NurseLine is available to you at no cost. To use this convenient service, simply call (800) 299-0274.

Is your 1 a.m. asthma attack cause for a trip to the ER?

Call NurseLine toll-free at (800) 299-0274, any time, 24 hours a day, seven days a week. You can count on NurseLine to help answer your health questions.

Note: If you have a medical emergency, call 911 instead of calling NurseLine.

Helpful Numbers and Information

BCBS 877-284-1571	
For This Service…	**Call During These Hours…**
Personal Health Support	7 a.m. - 6 p.m. CST Monday – Friday
Pre-Authorization/Case Management	7 a.m. - 6 p.m. CST Monday – Friday

www.bcbsil.com/sprint Life & Career>Benefits Plan Information>Benefits Overview
CVS Caremark **855-848-9165**
www.caremark.com Life & Career>Benefits Plan Information>Benefits Overview
Employee Help Line (EHL)
i-Connect ehlticket Or 800-697-6000

When Coverage Ends

For information on when your coverage under the Plan ends, see the separate *Eligibility & Enrollment* and *Life Events* Sections of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

Extended Benefits

If you or one of your Covered Dependents is Totally Disabled on the date his/her coverage under this Plan ends, Plan Benefits are payable with respect to the condition that caused the Total Disability as if the coverage had not ended. These "Extended Benefits" will be based on the terms of the Plan in effect on the date the coverage ended.

Extended Benefits are payable until the earliest of the:

- date the person is no longer Totally Disabled by the condition that caused Total Disability;
- end of the calendar year following the calendar year in which the coverage ended;
- date the person becomes eligible for benefits that are similar under any other group arrangement, whether insured or self-insured; or
- date the Plan ends or the date coverage ends for the class of Members of which the person is a member.

Totally Disabled/Total Disability means, if, due to an accidental Injury or Illness:

- in the case of a Sprint employee, the person is unable to do any work for compensation or gain; and
- in the case of a Member who is not a Sprint employee, the person is unable to do all the normal tasks for that person's age and family status.

This Plan coordinates benefits with other group coverage you may have.

Once you become eligible for Medicare, coordination of benefits may change — see the *Medicare and this Plan* section below.

Coordination of Benefits

When You Are Covered by More than One Plan

Today, many people are covered by more than one group medical plan. If this applies to you (or your Covered Dependents), you must let the Claims Administrator know about the other coverage.

This Plan, like most group plans, has a *coordination of benefits* provision for these situations. The provision coordinates benefits from all group medical plans — including benefits paid under a prepayment, employer sponsored or government program, **including** Medicare — covering you and your Covered Dependents. That is, this Plan and other group medical plans work together to pay covered health expenses. This Plan's COB provision does this by determining which plan is primary (see below).

Coverage, however, is *non-duplicative*. **So, if you have coverage under more than one group medical plan, including this one, this Plan, together with payments from other plans, will never pay more than what you would have received if this were your only plan.**

> If this Plan is primary, Benefits will be paid as if no other plan exists.
>
> If this Plan is the secondary payer, Benefits from this Plan will be paid to the extent that, when benefits from both plans are added together, the total is not more than what this Plan would have paid if no other plan exists. To do this, Benefits will be calculated under this Plan as if it were primary. Then, this Plan will subtract what was paid by the other plan and pay the remaining amount (if any) — up to the total that would have been paid under this Plan alone.
>
> When this Plan is secondary, the Allowable Expense is the primary plan's Network rate or reasonable and customary charges. If both the primary plan and this Plan do not have a contracted rate, the Allowable Expense will be the greater of the two plans' reasonable and customary charges. An Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When you incur Covered Health Expenses, you must submit a claim to the primary plan **before** the secondary plan. Once you receive benefits from the primary plan, you can submit a claim to the secondary plan. You must include a copy of payment or the Explanation of Benefits from the primary plan.

Which Plan Is Primary?

Except as explained in the *Medicare and this Plan* Section below, the Claims Administrator 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.

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.

Medicare and this Plan

A Note about 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.

It is important to enroll in Medicare coverage when you are first eligible if you are, or your coverage under this Plan is through a Member who is, no longer a Sprint employee.

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.

Impact of Medicare Eligibility or Entitlement

Medicare rules generally require this Plan to remain primary even when Medicare Part A becomes effective, except as provided below. This means:

- When this Plan is primary to Medicare for a person, then, just as described in the *Coordination of Benefits* Section above, Plan Benefits will be paid for that person's Eligible Health Care Expenses as if no other plan exists. If any bills remain unpaid after the Plan has paid to the limits of its coverage, then you would file a claim with Medicare.
- Your penalty-free enrollment period for optional Medicare coverage will be extended until after your coverage under this Plan ends, or, if earlier after 30 months of Medicare coverage due to ESRD.

The first exception is that the Medicare rules do not require this Plan to remain primary for domestic partners and their children. At Sprint'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.

The second exception is that when your coverage under this Plan continues after the Sprint employee's termination of employment (e.g., during any period of COBRA continuation or the employee's receiving Sprint Long-Term Disability Benefits):

- This Plan will become secondary for any Member becoming Medicare-eligible, and, just as described in the *Coordination of Benefits* section above, Benefits under this Plan will be reduced by the benefits paid by Medicare, the primary plan.
  - Benefits from this Plan will be paid to the extent that, when benefits from both this Plan and Medicare are added together, the total is not more than what this Plan would have paid if no other plan exists.
  - Claims must first be filed with Medicare and then with this Plan. When you receive an Explanation of Medicare Benefits form, submit it to the Claims Administrator along with your Plan claim form.
- This Plan assumes the Medicare-eligible Member has Part A and Part B Medicare and any benefits payable from this Plan for that person will be reduced by the amount that is or would be covered by each part, **whether or not he or she is enrolled in Medicare**; and
- This Plan will no longer consider **Prescription Drugs as a Covered Health Care Supply for the Medicare-eligible Person, whether or not he or she is enrolled in Part D.** This Plan will issue a Notice of Creditable Coverage to the applicable person.

Once this Plan becomes secondary to Medicare for you, you may wish to end your coverage. If you do, and you are a former Sprint employee, any of your Covered Dependents will remain covered under this Plan in their own right.

The Plan's Rights

The Plan has rights that are described in detail in the Sprint Welfare Benefits Plan for Employees, of which the Plan is a part. A copy of the Welfare Benefits Plan for Employees can be obtained by contacting the EHL (ehlticket or 800-697-6000). Any Benefits paid by the Plan are deemed made on the condition of these rights, some of which are:

- subrogation rights, which means that if a Member receives benefits under the Plan and has a claim for recovery against another party, that claim will belong to the Plan up to the amount of Benefits paid. The Member is required to assist the Plan in enforcing its subrogated claim.
- the right to recover Benefits that were made in error, advanced during the period of meeting the Deductible or Out-of-Pocket Limit, due to a mistake in fact, or because a Member misrepresented facts. If the Plan provides a Benefit that exceeds the amount that

should have been paid, the Plan will require that the overpayment be returned when requested, or reduce a future Benefit payment for the applicable Member by the amount of the overpayment.

- a right to reimbursement, which means that if a third party causes an Illness or Injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Illness or Injury.

Legal Information

For other important information about the Plan Sponsor and Administrator, Sprint employers participating in the Plan, Plan identification, agent for service of legal process, ERISA rights, including claims and appeals procedures, and other legally required notices regarding the Plan, see the separate *Legal Information* Section of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

Definitions

This section defines terms that are used throughout this Coverage Information Section of the Summary Plan Description.

Allowable Amounts means the following:

1. For Covered Health Services and Supplies from a Network Provider, the contracted rates with the Provider;
2. For Covered Health Services and Supplies from a Non-Network Provider for a Member's Emergency, the amounts billed by the Provider, unless the Claims Administrator negotiates lower rates; and
3. For other Covered Prescription Drugs, the comparable network Provider rate, and for other Covered Medical Health Services and Supplies from a Non-Network Provider, one of the following, as applicable:
   - negotiated rates agreed to by the Non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator;
   - 200 (100 with respect to Providers in Illinois) percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar Service or Supply within the geographic market;
   - When a rate is not published by CMS for the Medical Service or Supply, the Claims Administrator uses an available gap methodology to determine a rate for the Medical Service or Supply as follows –
     - For Service or Supply other than Doctor-administered Pharmaceutical Products, BCBS uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the Service or Supply. The relative value scale currently used is created by Ingenix. If the Ingenix relative value scale becomes no longer available, a comparable scale will be used. BCBS and Ingenix are related companies through common ownership by BCBS.
     - For Doctor-administered Pharmaceutical Products, BCBS uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals; or

- When a rate is not published by CMS for the Service and a gap methodology does not apply to the Medical Service, or the Provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, 50% of the Provider's billed charge (80% of the Provider's billed charge for Mental Health/Substance Use Disorder Services, reduced by 25% for Services provided by a psychologist and by 35% for Services provided by a masters level counselor).

Allowable Amounts are subject to the Claims Administrator's reimbursement policy guidelines, which are applied in its discretion, a copy of which related to your claim is available upon request to the Claims Administrator.

Alternate Facility means a health care facility that is not a Hospital that, as permitted by law, provides Emergency, surgical, rehabilitative, laboratory, diagnostic, therapeutic on an outpatient basis, or with respect to Mental Health/Substance Use Disorder Services on an outpatient or inpatient basis, including an Urgent Care Center, Birthing Center, Skilled Nursing Facility or Rehabilitation Facility.

Attending Doctor means a Doctor who is in charge of the Patient's overall medical care and responsible for directing his or her treatment program.

Benefits means the Plan payments for Covered Health Expenses, subject to the terms and conditions of the Plan. *Benefits* are your Benefit Levels.

Benefit Levels means the percentage of Covered Health Expenses payable by the Plan during and after the Coinsurance phase of coverage.

Brand-name Drug means a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by CVS Caremark as a Brand-name Drug based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name or Generic Drugs based on a number of factors.

Not all products identified as "brand name" by the manufacturer, Pharmacy, or your Doctor are classified as Brand-name by CVS Caremark.

Claims Administrator – see page 1

COE means a Center of Excellence, which is a clinically superior, cost-effective health care center for complex medical conditions, as identified by BCBS.

Coinsurance – see page 3.

Coordination of Benefits means a provision that coordinates benefits from all group medical plans.

Compounded means those medications containing two or more ingredients that are combined "on-site" by a pharmacist, provided at least one of the ingredients is covered by the Plan.

Congenital Anomaly means an abnormality or malformation of the structure of a body part, such as curvature of the 5th finger (clinodactyly), a third nipple, tiny indentations of the skin near the ears (preauricular pits), shortness of the 4th metacarpal or metatarsal bones, or dimples over the lower spine (sacral dimples).

Cosmetic means primarily for appearance purposes, as opposed to physiological function, for example: reshaping a nose with a prominent bump because appearance would be improved, but there would be no improvement in function like breathing; liposuction; pharmacological regimens; nutritional procedures or treatments; tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure; physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation; weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; treatments for hair loss or replacement; a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy; varicose vein treatment of the lower

extremities; wigs except as covered under Wigs; and treatment of benign gynecomastia (abnormal breast enlargement in males).

Covered Dependent means a Sprint employee's spouse/domestic partner or dependent child who is properly enrolled in this Plan pursuant to the *Eligibility and Enrollment* Section of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

Covered Health Expense – see page 6.

Covered Health Service or Supply – see page 7.

Custodial Care means a Service that does not require special skills or training or is provided by a Personal Care attendant and that:

- provides assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- is provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- does not require continued administration by trained medical personnel in order to be delivered safely and effectively.

DAW means "Dispense as Written;" i.e., your Provider's instruction to not allow substitution of a Therapeutically Equivalent Prescription Drug for the prescribed Brand-name Prescription Drug.

Deductible – see page 2.

Dental means of or related to diagnosis (e.g., oral evaluations, examinations, x-rays/films, lab tests, casts), prevention (e.g., dental prophylaxis (dental cleanings), topical fluoride treatments, nutritional counseling for dental disease, tobacco counseling for oral disease, oral hygiene instructions, sealants, space maintainers) or treatment (see below) of diseases, disorders and conditions of the oral cavity, the maxillofacial area and the adjacent and associated structures. Dental treatment includes Services and Prescription Drugs and other Supplies that are (a) restorative (e.g., amalgam restorations (silver fillings), resin restorations (white fillings), gold foil restorations, inlay/onlay restorations, crowns, core buildups, posts); (b) endodontic (e.g., pulp capping, pulpotomy, pulpal therapy, root canals, apicoectomy); (c) periodontic (e.g., gingivectomy, gingivoplasty, crown lengthening, osseous surgery, grafting procedures, provisional splinting, scaling and root planing, full mouth debridement, periodontal maintenance); (d) prosthodontic (removable or fixed) (e.g., complete dentures, partial dentures, interim dentures, denture repairs, denture rebase, denture reline, denture pontics, denture inlays/onlays, denture crowns, dental implants, retainers); (e) surgical (e.g., extractions, excisions, alveoloplasty (surgical preparation for dentures), vestibuloplasty (surgery to increase alveolar ridge height); (f) orthodontic (e.g., appliance therapy, orthodontic braces, retainers); and (g) adjunctive (e.g., anesthesia, occlusal guards (bite plates/guards), athletic mouthguards, occlusal adjustments to teeth, teeth bleaching).

Dentist means a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) licensed in the jurisdiction of practice with respect to the Patient.

Disposable means of or related to short term or single usage, whether or not consumable.

Doctor means a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) licensed in the jurisdiction of practice with respect to the Patient.

Durable Medical Equipment (DME) means items that are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Illness; are appropriate for use in the home; and are not Disposable.

Examples of DME include but are not limited to:

- equipment to assist mobility, such as wheelchairs;
- respirators;

- dialysis machines;
- equipment to administer oxygen;
- Hospital beds;
- delivery pumps for tube feedings;
- insulin pumps;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments
- braces that straighten or change the shape of a body part;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces;
- equipment for the treatment of chronic or acute respiratory failure or conditions; and
- speech aid devices and trachea-esophageal voice devices for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury.

DME excludes hygienics or self-help items; environmental controls, institutional, or convenience equipment; equipment used for participation or safety in sports or recreational activities; blood pressure cuff/monitor, enuresis alarm, non-wearable external defibrillator, trusses, ultrasonic nebulizers; devices and computers to assist in communication and speech except for speech aid and tracheo-esophageal voice devices; and fixtures to real property such as ramps, railings and grab bars.

Emergency means a Medical Condition that arises suddenly and in the judgment of a reasonable person requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Experimental or Investigational means a Service or Supply (other than Prescription Drugs during an Inpatient Stay), which at the time of its receipt is: 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; or subject to review and approval by any institutional review board for the proposed use, except devices that are FDA-approved under the *Humanitarian Use Devise* exemption; or the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2, 3 or 4 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Explanation of Benefits means a statement describing payment processing of your claim. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment and show the portion of the claim you need to pay. If you would like paper copies of the EOBs under this Plan, you may call the toll-free number on your Member ID card to request them. You can also view and print all of your EOBs online at the applicable Claims Administrator's website.

Generic Drug means a Prescription Drug that is not a Brand-name drug and either:

- contains the same active ingredient as a Brand-name Drug; or
- is identified by CVS Caremark as a Generic Drug based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name or Generic Drugs based on a number of factors.

All products identified as a "generic" by the manufacturer, Pharmacy or your Doctor may not be classified as a Generic by CVS Caremark.

Home Health Agency means a program or organization authorized by applicable law to provide health care services in the home.

Hospice Care means a Service that provides a coordinated plan of home and inpatient care that treats a terminally ill patient and his or her family as a unit. The service provides care to meet the special needs of the family unit during the final stages of a terminal illness and during bereavement up to 12 months after the Member's death. A team of trained medical personnel, homemakers and counselors work under a BCBS-approved independent hospice administration, approved by all

state or local licensing requirements, to provide care and to help the family unit cope with physical, psychological, spiritual, social and economic stress.

Home Health Care means an alternative health care Service that a Home Health Agency provides that mainly provides Skilled Care, is legally qualified in the state or the locality in which it operates, and keeps clinical records on all patients. The term does not include Services of a social worker or home health aide or Services of a homemaker or caretaker, including but not limited to sitter or companion services, transportation, house cleaning, and maintenance of the home, or other Custodial Care.

Hospital means a legally constituted and operated institution that is primarily engaged in providing inpatient diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of sick persons under the supervision of staff doctors who are duly licensed to practice medicine, and which provides nursing service 24 hours a day by registered graduate nurses — physically present and on duty. A Hospital is not an institution (or part of an institution) that is mainly used for rest care, nursing care, convalescent care, elder care, care of the chronically ill, Custodial Care or educational care.

Illness means physical illness, disease or pregnancy.

Injury means bodily damage from trauma other than Illness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility means a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by applicable law.

Inpatient Stay means an uninterrupted confinement in, following formal admission to, a Hospital, Skilled Nursing Facility, or Rehabilitation Facility.

Intensive Outpatient Treatment means a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Life Event – see Life Events Section of the SPD herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

Medical means of or related to diagnosing, treating or preventing Medical Conditions.

Medical Condition means Illness, including Mental Health or Substance Use Disorders, or Injury, and its symptoms.

Medically Necessary/Medical Necessity means for the purpose of preventing, evaluating, diagnosing or treating a Medical Condition and:

- in accordance with *Generally Accepted Standards of Medical Practice*;
- clinically appropriate (in terms of type, frequency, extent, site and duration) and effective for your Medical Condition;
- not mainly for your convenience or that of your Doctor or other Provider; and
- not more costly than an alternative Service or Supply that is at least as likely to produce equivalent therapeutic or diagnostic results, as specified in the Claims Administrator's clinical policies.

  Generally Accepted Standards of Medical Practice are standards that are based on (a) 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; or if not available (b) standards based on Doctor specialty society recommendations or professional standards of care.

Medicare means Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member means a person properly enrolled for coverage under this Plan pursuant to the rules described in the *Enrollment & Eligibility Section* of the SPD incorporated herein by reference on the Benefits site of i-Connect under Summary Plan Descriptions.

Network means the network of Providers under this Plan selected by the Claims Administrator within which amounts charged the Provider are negotiated, contracted rates and are automatically considered Allowable Amounts.

Network Provider means a health care Provider who has entered into an agreement with the Claims Administrator or an affiliate and agreed to accept specified reimbursement rates for Covered Health Services and Supplies.

Non-Emergency means Services or Supplies that are provided to a Member in a situation that does not meet the criteria for being an Emergency.

Non-Network means Services or Supplies provided outside of the Plan's Network.

Non-preferred Brand-name Drug means a Brand-name Drug that is not identified by CVS Caremark as being on the Preferred Drug List (PDL).

Out-of-Pocket Limit – see page 3.

Partial Hospitalization/Day Treatment means 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.

Patient means a Member of this Plan who receives Medical Services or Supplies.

Pharmaceutical Products means certain injectable drugs allergy sera or extracts that, due to their characteristics (as determined by BCBS), must typically be administered or directly supervised by a Doctor but not typically available by prescription order or refill at a Pharmacy.

Pharmacy means a retail or home delivery organization lawfully dispensing Prescription Drugs.

Plan means The Sprint Basic Medical Plan.

Plan Administrator means the Employee Benefits Committee of Sprint.

Plan Sponsor means Sprint Communications, Inc. (Sprint).

Preferred Drug List (PDL) – means the list at www.sprint.com/benefits that categorizes Prescription Drugs into the following three tiers, taking into account a number of clinical and economic factors regarding Members as a general population, including relative safety and efficacy, the acquisition cost of the Prescription Drug, and available rebates and assessments on the cost effectiveness of the Prescription Drug:

Tier 1: Generic
Tier 2: Preferred Brand-name
Tier 3: Non-preferred Brand-name

The PDL category status of a Prescription Drug can change periodically without notice; visit www.caremark.com or call Caremark at the toll-free number on your Rx Member ID card for the most current information.

Prescription Drug means a medication or other Supply (excluding Durable Medical Equipment except inhalers and Diabetic Supplies and excluding Pharmaceutical Products other than Depo Provera and other injectable drugs used for contraception) that:

- contains at least one ingredient that has been approved by the Food and Drug Administration, and
- can be dispensed legally, under federal or state law, only pursuant to a prescription order or refill.

Preventive Prescription Drugs means those Prescription Drugs and limited over-the-counter drugs with a Doctor's Prescription, which are listed at www.sprint.com/benefits.

Preventive Services means Services that have been demonstrated by clinical evidence to be safe and effective in either the early detection or the prevention of disease, have been proven to have a beneficial effect on the health outcomes and include the following as described at www.sprint.com/benefits and modifications to limits published therein based on Medical Necessity.

Private Duty Nursing means nursing care that is provided to a Patient for a period greater than four hours per day on a one-to-one basis by licensed nurses.

Prosthetic Devices means items that replace a limb or body part, or help an impaired limb or body part work, such as artificial limbs, legs, feet, hands, eyes, ears, nose and face; breast prostheses, including mastectomy bras and lymphedema stockings for the arm; and internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts.

Provider means a Pharmacy, Hospital, Alternate Facility, Doctor, Dentist, or other licensed medical professional who is ***not*** at the time the Service is rendered:
- the Patient's family member by birth or marriage, including his/her spouse, brother, sister, parent or child
- living at the same legal residence as the Patient;
- a Christian Science practitioner; or
- an unlicensed Provider or a Provider who is operating outside of the scope of his/her license; or
- sanctioned under a federal program for fraud, abuse or medical incompetency.

Qualifying Clinical Trial means a phase 1, 2, 3 (or 4 for cancer or other life threatening conditions) trial conducted in relation to the prevention, detection, or treatment of (a) cancer or other life-threatening disease or condition, (b) cardiovascular disease (cardiac/stroke), (c) surgical musculoskeletal disorders of the spine, hip and knees, or (d) other diseases or disorders, which are not life threatening for which a clinical trial is:
- federally approved or funded,
- conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; or
- a drug trial that is exempt from having such an investigational new drug application.

Routine Patient Care for Clinical Trials means:
- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the Investigational Supply or Service, the clinically appropriate monitoring of the effects of the Supply or Service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational Supply or Service.

Routine Patient Care for Clinical trials does not include:
- The Experimental or Investigational Service or Supply except certain Category B devices, certain promising interventions for patients with terminal illnesses and other Supplies and Services that meet specified criteria in accordance with our medical and drug policies;
- Supplies and Services provided solely to satisfy data collection and analysis needs 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
- Supplies and Services provided by the research sponsors free of charge for the trial enrollee.

Service means a Medical examination, diagnosis, or treatment, including prevention, Surgery, therapy and related care by a Provider.

Skilled Care means skilled nursing, teaching, and rehabilitation Services that require clinical training in order to be delivered safely and effectively, are 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, and are not Custodial Care.

Skilled Nursing Facility means a nursing facility that is licensed and operated as required by applicable law, including that which may be part of a Hospital.

Sprint means Sprint Corporation and, as applicable, any of its subsidiaries participating in the Plan.

Supply means a Medical product, including a Pharmaceutical Product, a Prescription Drug, a Disposable Medical Supply or Durable Medical Equipment.

Surgery to Change Secondary Sex Characteristics means thyroid chondroplasty (reduction of the Adam's Apple), bilateral mastectomy, and augmentation mammoplasty (including breast prosthesis if necessary) if the Doctor prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

Therapeutically Equivalent means having essentially the same efficacy and adverse effect profile.

Urgent Care Center means an Alternate Facility that provides care or treatment of an acute medical problem that requires prompt professional attention but is not life-threatening, for example, a sprain, severe earache, and nausea or migraine headache.