Sprint Plans
Legal Information Section

What is Inside

Overview

This Section constitutes part of a Summary Plan Description for, and provides important details about your legal rights as a participant in, the "Sprint Plans," which are the Dependent Care Flexible Spending Account and the following Sprint Communications, Inc. ("Sprint") group health plans or portions thereof that are *self-funded*:

- Medical Plans, including prescription drug coverage
  - Basic Plan
  - Core Plan
  - Health Account Plan
- Dental Plan
- Vision Plan
- Health Care Flexible Spending Account Plan
- Health Reimbursement Account ("HRA")

"Self-funded" means the benefits payable on behalf of you and your dependents are paid from a combination of the general assets of Sprint and employee contributions. Any dividends, subsidies, credits or refunds that may become payable under a Sprint Plan or as a result of Employer providing benefits will not be assets of a Sprint Plan but will be the property of the Employer, unless otherwise required by applicable law.

NOTE: This Legal Information Section also applies to the fully insured plans (HMO Medical Plans, TRICARE Supplement Medical Plan, Basic Employee, Supplemental and Dependent Life, Supplemental/Dependent Accidental Death and Dismemberment, Basic/Supplemental Long-Term Disability, and Legal Services Plan) only to the extent not superseded by the applicable insurance policies/certificates provided by the applicable insurer or *Coverage Information* Section.

NOTE: The Dependent Care Flexible Spending Account Plan is not subject to ERISA and is not considered a Sprint Plan with respect to references herein to rights under ERISA but is so considered only for purposes of general information herein.

Plan Sponsor

Sprint Communications, Inc.
6200 Sprint Parkway
Overland Park, KS 66251
EIN: 48-0457967

Plan Administrator

Sprint selected the Employee Benefits Committee of Sprint as Plan Administrator, as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), for the Sprint Plans and is located at:

Sprint Communications, Inc.
6360 Sprint Parkway
Overland Park, KS 66251

The Plan Administrator has the sole and absolute discretionary authority to:

- interpret the terms and provisions of the Sprint Plans in order to make benefit decisions;
- make factual determination as to eligibility to receive benefits under the Sprint Plans; and
- make decisions and take any action with respect to questions arising in connection with the Sprint Plans.

However, Sprint has hired a "Third Party Administrator" ("TPA") for each self-funded Sprint Plan, which has assumed this claims administration discretionary fiduciary responsibility. The TPAs are listed at the end of this Section, and with respect to the Medical Plans, vary depending on your particular geographic location as more fully explained in the applicable *Coverage Information* Section on i-Connect > My Life & Career > Benefits > Benefits Summary Plan Descriptions.

NOTE: We, or one of our healthcare partners, may provide you notice about information relating to your health care plan or benefits through one or more of the following: correspondence to your last known billing address, to your Sprint e-mail address or a current e-mail address you've provided us, by calling your Sprint mobile telephone number (if applicable) or any other telephone number you've provided us, by voice message to your Sprint mobile telephone number (if applicable) or any other telephone number you've provided us, or by text message to your Sprint mobile telephone number (if applicable). For outreach by phone, calls may be placed to you using an automated phone or dialing system.

NOTE: The right to file claims and appeals and to receive information applies to you and your covered dependent. You or your covered dependent may designate someone else to act as your authorized representative for these rights. In that case, you must provide the TPA a signed and dated statement telling them who you are authorizing, and the references to "you" below apply to that representative.

If Your Enrollment Or Election Change Request Is Denied...

If you or your dependent(s) are denied benefits enrollment or an election change for failure to follow the terms of the enrollment process, see the *Eligibility and Enrollment* Section on i-Connect > Life & Career > Benefits > Benefits Summary Plan Descriptions.

If Your Dependent Eligibility Request is Denied...

As a reminder, only Eligible Dependents as defined in the *Eligibility and Enrollment Section* on i-Connect > Life & Career > Benefits > Benefits Summary Plan Descriptions may be covered under the applicable Sprint Plans.

Your right to an Appeal

If your request for dependent coverage is denied for failure to meet the criteria of an Eligible Dependent (a "claim" for which the requirements and deadlines are explained herein), you have the right to appeal that denial. There is one level of internal appeal. If you do not timely file your internal appeal and the deadline expires, there are no other Sprint options or recourse available to you, and your appeal will be deemed denied.

On appeal, you may submit written comments, documents, records and other information relating to your appeal. You may request and will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to your appeal. Sprint's review will not afford deference to the prior determination and will be conducted by an appropriate fiduciary not connected

with the prior determination

Once you have timely filed an appeal, Sprint will review your appeal and provide a response within the applicable deadline. If additional information is needed to render a decision, you will be asked, and will be given a reasonable time, to provide it. In this case, Sprint is allowed an extension to make its determination and will notify you if and why this is necessary and the revised response deadline.

If you have any questions about the below appeal process, please contact the Employee Help Line at (800) 697-6000.

Internal Appeal Process

If your dependent coverage claim is denied, you may file an appeal to Sprint within 180 calendar days following receipt of notification of the initial adverse determination. Appeals must include documentation supporting your dependent eligibility claim. Appeals filed after the appeal deadline will not be reviewed.

Appeals must be sent by fax to:

Sprint Health and Productivity Benefits ATTN:
Benefit Appeals
(866) 523-8544

You will receive a response to your appeal within 60 calendar days of receipt at the above fax by Sprint. The response will provide the specific reason(s) for any denial in writing or by electronic notification, including:

1. reference to the specific plan provision(s) on which the denial is based, including any internal rule, guideline or protocol, or the availability of that information upon request; and
2. a description of any additional material or information necessary for you to provide to perfect the appeal and an explanation of why such material or information is necessary; and
3. a description of any additional appeal procedures available to you.

Making A Claim For Benefits...

What is a Claim?

ERISA provides you the right to make a claim to the Sprint Plans for benefits. A claim is a request for the Sprint Plan to pay directly or reimburse you for services you have already received or to pre-authorize benefit coverage for a future service.

Types of Claims

There are different types of claims in the Sprint group health Plans, each of which has different procedures and deadlines, as discussed in this section.

Pre-Service claims are requests that the Sprint Plan provide or pay for a service that you have not yet received – i.e., when you want the TPA to make a benefit determination before you actually receive the services. Pre-Service claims are further divided in type depending on your medical circumstances in relation to the applicable deadlines:

Urgent: The relevant TPA will consider your Pre-Service claim Urgent if following the Non-Urgent deadlines would: A) seriously jeopardize your life or health or the ability for you to regain maximum function; or B) in the opinion of a physician with knowledge of your medical condition may subject you to severe pain that cannot be adequately managed without the services you are requesting.

Non-Urgent: The relevant TPA will consider your Pre-Service claim Non-Urgent unless it meets the criteria for being an Urgent Pre-Service claim.

Post-Service Claims are requests that the Sprint Plan provide or pay for a service that

you have already received – i.e., when you are seeking a benefit determination after you received the services. If you receive service(s) for which you have made a Pre-Service Claim before the TPA makes its determination, your claim will become a Post-Service claim.

Filing a Claim

Typically your health care provider will file the claim directly to the TPA. However, sometimes you are responsible for filing the claim. Be sure to confirm with your health care provider who should file the claim to avoid any unnecessary delays in the determination on your claim.

Claims may be filed verbally, to the extent allowed by the TPA procedures, or in writing. You may submit written comments, documents records and other information relating to your claim. You may request and will be provided free of charge reasonable access to and copies of all documents, records, and other information relevant to your claim.

If you fail to follow the procedures for filing a Pre-Service claim but have submitted minimal identifying information on your claim to the TPA, the TPA will notify you of the failure and procedures to be followed for filing such a claim within 5 days (24 hours for an Urgent Pre-Service claim) of such failure.

Please refer to the *Coverage Information* Section for the applicable Sprint Plans for Claim filing details and contact information.

Claim Determinations

Next, the TPA will review your claim. You will receive an Explanation of Benefits showing the portion, if any, of your claim that the TPA has determined is covered. If your claim is denied in whole or in part, the TPA must respond to your claim within the applicable deadline.

If the TPA needs additional information to render a decision, you will be asked, and will be given a reasonable time, to provide it. In this case, the determination deadline will not be; instead time is in effect "paused" and resumes once the additional information is received or the deadline for submission of the information has expired. In some cases, the TPA may extend the timeframe needed to make a determination and will notify you if and why this is necessary and the expected response time.

The ERISA deadlines for the claim determination process are as follows:

Plan	Type of Claim	TPA Claim Determination Deadline	TPA Deadline to Ask for Information and/or Extend Deadline	Your Deadline to Submit Additional Information	TPA Extension of Determination
Medical (employee)	Urgent Pre-Service Healthcare	ASAP*, no later than 24 hours after receipt of claim ** & ***	Within 24 hours after receipt of claim	At least 48 hours after request	N/A
Medical, Dental, Vision	Urgent Pre-Service Healthcare	ASAP*, no later than 72 hours after receipt of claim ** & ***	Within 24 hours after receipt of claim	At least 48 hours after request	N/A
Healthcare	Non-Urgent Pre-Service Healthcare	Not later than 15 days after receipt of claim***	Within 15 days after receipt of claim	At least 45 days after receipt of request	Up to 15 days

*Taking into account the medical exigencies of the claim.
**If related to your request to extend a course of treatment longer, within 24 hours of your request if you make your request at least 24 hours before the course would have ended.
***If the TPA decides to reduce or end a course of treatment early, the TPA must notify you sufficiently in advance to allow you to appeal and get a determination on appeal before the reduction or end of the course of treatment.

The TPA must provide the specific reason(s) for any denial in writing or by electronic notification (except that for Urgent Pre-Service claims, to which the TPA may respond orally followed by written or electronic notification). The TPA must also provide:

1. claim identification information, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
2. reference to the specific plan provision(s) on which the denial is based, including
    a. any internal rule, guideline or protocol, or the availability of that information upon request, and/or
    b. an explanation of scientific or clinical judgment for a "medical necessity" or "experimental treatment" or similar basis for denial, or the availability of that information upon request including the name of any medical expert whose advice was obtained on behalf of the plan;
3. a description of any additional material or information necessary for you to provide to perfect the claim and an explanation of why such material or information is necessary; and
4. a description of the appeal procedures and deadlines (as described below), including an explanation of your right to request an expedited appeal for Urgent Pre-Service claims, which must include the exchange of information via phone, fax or other expeditious method.

If Your Claim Is Denied…

Generally
ERISA also provides you the right to appeal to the TPA if you disagree with the denial of your claim. An appeal is a request for the TPA to review and reconsider its decision to deny all or part of your claim.

The TPA's review will not afford deference to the prior determination and will be conducted by an appropriate fiduciary not connected with the prior determination. If the denial was based on medical judgment, the TPA will:

1. consult with a health care professional who has appropriate training and experience in the field of medicine involved; and
2. identify the expert(s) not connected with the prior determination whose advice was obtained in connection with the review.

Filing an Appeal
For the Sprint group health Plans, there are two levels of internal appeal with the TPA. If you do not timely file one or both internal appeals and the deadlines expire, there are no other options or recourse available to you, internally or externally, and your appeal(s) will be deemed denied.

On appeal, you may submit written comments, documents records and other information relating to your appeal. You may request and will be provided free of charge reasonable access to and copies of all documents, records, and other information relevant to your appeal.

Appeal Deadlines
Once you have timely filed an appeal, the TPA will review your appeal. If your appeal is denied in whole or in part, the TPA must respond to your claim within the

applicable deadline. If the TPA needs additional information to render a decision, you will be asked, and will be given a reasonable time, to provide it. In this case, the appeal response deadline will not be impacted; instead time is in effect "paused" and resumes once the additional information is received or the deadline for submission of the information has expired. In some cases, the TPA may extend the timeframe needed to make a determination and will notify you if and why this is necessary and the expected response time.

The ERISA deadlines for the first level internal appeal process are as follows:

Plan	Type of Claim	Your Deadline to File 1st Appeal to TPA	TPA Appeal Determination Deadline
Medical (employee)	Urgent Pre-Service Healthcare	180 days after receipt of notice of denial	ASAP, no later than 24 hours after receipt of appeal*
Medical, Dental, Vision	Urgent Pre-Service Healthcare	180 days after receipt of notice of denial	ASAP, no later than 72 hours after receipt of appeal*
Healthcare	Non-Urgent Pre-Service Healthcare	180 days after receipt of notice of denial	Not later than 15 days after receipt of appeal

Taking into account the medical exigencies of the claim.

You may file one courtesy appeal to the Dependent Care Flexible Reimbursement Account Plan Claims Administrator within 180 days after receipt of notice of the claim denial.

If the TPA denies your first appeal, it must provide the same information as described above for the claim determination in writing or by electronic notification (except for Urgent Pre-Service appeals, the response may be oral followed by written or electronic notification within three days thereafter) and additionally state that you may request and will be provided free of charge reasonable access to and copies of all documents, records, and other information relevant to your appeal.

The ERISA deadlines for the second level appeal process are as follows:

Plan	Type of Claim	Deadline to File 2nd Appeal to TPA	Appeal Determination Deadlines
Medical (employee)	Urgent Pre-Service Healthcare	60 days from receipt of denial notice	ASAP, no later than 24 hours after receipt of appeal
Medical, Dental, Vision	Urgent Pre-Service Healthcare	60 days from receipt of denial notice	ASAP, no later than 72 hours after receipt of appeal
Healthcare	Non-Urgent Pre-Service Healthcare	60 days from receipt of denial notice	Not later than 15 days after receipt of appeal
Healthcare	Post-Service Healthcare	60 days from receipt of denial notice	Not later than 30 days after receipt of appeal

If the TPA denies your second appeal, it must provide the same information as described above for the first appeal, providing information about your options as described below.

If Your Final Appeal Is Denied...

For the Sprint employee medical Plans, if, and only if, you timely filed a first and second appeal to the TPA, you may file within four months of receipt of the second appeal denial a written request for an external appeal to an independent health care professional, who has no association with the TPA or us, if the denial involved medical necessity, experimental/investigational nature of the service, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.

- The appeal request and documentation must be submitted to the TPA who will forward to an eligible independent health care professional for review.
- For standard external review, a decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review of our denial. Please review the *Coverage Information* Section on i-Connect > My Life & Career > Benefits > Benefits Summary Plan Descriptions or contact the TPA.
- The decision of the external review is final and binding on the Plan.

For all Sprint Plans, if, and only if, you timely filed required appeals, you may file suit for civil action under ERISA §502(a)(1)(B).

If Coverage is Rescinded...

Enrolling, attempting to intentionally enroll or intentionally maintaining enrollment for ineligible persons or making an intentional misrepresentation of material fact is considered misrepresentation and/or fraud, which is strictly prohibited by the Sprint Flex Plans and will result in (a) the immediate end of coverage for such person retroactive to the date of the person's ineligible coverage and your obligation to repay any benefits paid after that date by a Sprint Flex Plan on behalf of such person and (b) applicable employment and/or income tax consequences.

You will be notified 30 days in advance of the retroactive removal of your or your dependent(s) coverage..

Your ERISA Rights

Protection For You...ERISA gives you certain rights as a participant in Sprint's Plans.

You have rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) related to the Sprint Plans. Here is a look at these rights…

- You may examine — without charge — Sprint Plan documents at the office of the Employee Help Line (EHL) or at other specified locations. Sprint Plan documents include Summary Plan Descriptions and the annual financial statement and official documents filed with the U.S. Department of Labor and the Internal Revenue Service.
- You may obtain copies of Sprint Plan documents and other information about any Sprint Plan, including a summary of the Sprint Plan's annual financial report, by writing to:

  Sprint Health and Productivity Benefits
  KSOPHE0210 - 2B400
  6360 Sprint Parkway
  Overland Park, KS 66251

  or by contacting:

Employee Help Line (EHL)
Intranet **ehlticket** **Or** **800-697-6000**

There may be a reasonable charge for copies.

In addition to creating rights for Sprint Plan participants, ERISA imposes duties upon the people who operate the Sprint Plan — called fiduciaries. Fiduciaries must act in the interest of the participants and beneficiaries of the Sprint Plan. They must exercise prudence and good judgment in the performance of their duties and in the disposition of Plan money. Also, you cannot be discharged or discriminated against for pursuing a benefit or for exercising your ERISA rights.

There are steps you can take to enforce the above-described ERISA rights. For instance, if you request a copy of Sprint Plan documents or the latest annual report from the Sprint Plan and do not receive them within 30 days, you may file suit in a federal court. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If Sprint Plan fiduciaries misuse Sprint Plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — if, for example, it finds your claim is frivolous.

If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

Qualified Medical Child Support Order (QMSCO) Procedures

Upon receipt of a judgment, decree or order issued by a court of competent jurisdiction, including approval of a property settlement (an "Order"), which provides for child support with respect to a child of a participant under the Sprint Plan(s) or provides for health benefit coverage to such a child, or which enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Sprint Plan and which is made pursuant to a state domestic relations law or community property law, the Plan Administrator will perform the following functions as promptly as possible:

(a) Notify the employee/parent and any alternate recipient of the receipt of the Order.
(b) Send a copy of these QMCSO Procedures to:
    (1) the employee/parent and any alternate recipient at the last known mailing address or the mailing address specified in the Order, and
    (2) each representative (if any) who has been designated by an alternate recipient to receive copies of notices that will be sent to the alternate recipient with respect to the Order.

The Plan Administrator will review the Order and may request legal counsel to review the Order. As part of this review, the Plan Administrator will complete a QMCSO checklist developed for internal review purposes and may request legal counsel to review the completed checklist. A copy of the completed checklist will be provided to the parties upon request. The Plan Administrator will determine whether the Order is a QMCSO within a reasonable period of time after receipt of the Order. If the Plan Administrator determines that the Order satisfies all of the requirements for a QMCSO, the Plan Administrator will:

(a) Notify each person described above that the Order is a QMCSO, and
(b) Direct the Sprint Plan(s) to obey the Order.

If the Plan Administrator determines that the Order is not a QMCSO, the Plan Administrator will advise the parties to the Order (and their counsel, if any), that the Order is not a QMCSO and the reason(s) for that determination.

Mental Health Parity Act of 1996

To the extent any applicable Sprint Plan provides mental health benefits other than treatment for substance or alcohol abuse, it will not place annual or lifetime maximums for such benefits that are lower than the annual and lifetime maximums for physical health benefits. Such coverage shall be subject to any applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days and/or outpatient visits.

Government Rules Could Result In Additional W-2 Income

The government requires the Sprint Plans to pass special non-discrimination tests. The tests are designed to ensure that highly compensated employees do not receive a greater share of welfare plan benefits.

If the Sprint Plans do not meet the tests, highly compensated employees may have an additional federal income tax to pay in the form of imputed income. This would be in addition to any imputed income that may result from your life insurance election.

In addition, neither Sprint nor the Plan Administrator make any commitment or

guarantee that any amount paid to or for your benefits will, in all cases, be excluded from your gross income for federal or state income tax purposes. You should contact your own accountant or other tax professional to determine what amount, if any, would be subject to taxation by you individually.

Assignment of Benefits

Your Sprint Plans are used exclusively to provide benefits to you and your dependents, and, in some cases, your survivors. Except under certain limited circumstances as outlined in the Sprint Welfare Benefits Plans, your benefits cannot be assigned and transferred to another person or organization. Your benefits can never be attached or used as collateral for a loan.

Sprint Plans' Rights

Right of Recovery

The Sprint Plans have the right to recover benefits they have paid on behalf of you or your covered dependent that were made in error or due to a mistake in fact or because you or your covered dependent misrepresented a fact. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

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

If any of the Sprint Plans provide a benefit for you or your Dependent that exceeds the amount that should have been paid, the Sprint Plans will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means a Sprint Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for benefits that the Sprint Plan has paid. Subrogation applies when the Sprint Plan has paid on your behalf benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

A Sprint Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits it has paid on your behalf relating to any sickness or injury caused by any third party, which includes a requirement that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to a Sprint Plan 100% of any benefits you received for that sickness or injury from the Sprint Plan.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist

protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

As a participant under a Sprint Plan, you agree to the following:

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

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

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits from the Sprint Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Individual), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not

recovered by the Plan due to your failure to abide by the terms of the Plan. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Administrative Information

This section provides required information about the administration of the Sprint Plans.

Employer ID Numbers

This chart shows the Sprint subsidiaries that participate in the Sprint Plans and each employer's IRS identification number.

Employer Name	Identification Number
Pinsight Media +, Inc.	43-1891522
Sprint PR LLC	81-4728252
Sprint/United Management Co.	48-1077227
Sprint Federal Management LLC	46-3612831
UCOM, Inc.	48-0940606
US Telecom, Inc.	48-0934012
Virgin Mobile USA Evolution	81-2831078

Plan and TPA Identification and Information

Plan Name	Plan ID#/ Type	Plan Funding	Third Party Administrator (TPA)
Sprint Medical Plans: ◦ Basic Plan ◦ Core Plan ◦ Health Account Plan	715/ Welfare	Self-Insurance	UnitedHealthcare PO Box 30555 Salt Lake City, UT 84130-0555 (877) 468-0982 Blue Cross and Blue Shield of Illinois 300 East Randolph Street Chicago, Illinois 60601-5099 (800) 654-7385
Dental Plan	715/ Welfare	Self-Insurance	Delta Dental Plan of KS 1010 N. Main Wichita, KS 67203 (800) 733-5823
Vision Care Plan	715/ Welfare	Self-Insurance	Davis Vision 175 East Houston Street San Antonio, TX 78205 (800) 383-0104
Health Care Flexible Spending Account Plan	715/ Welfare	Participating Employees	WageWorks, Inc. 5200 Commerce Drive Suite 100 Louisville, KY 40299 (800) 654-6695

2016 CMS Health Plan Identifiers (HPID)

Plan	Assigned HPID
Sprint Basic Plan	7376546421
Sprint Health Account Plan	7467455516
Sprint Consumer Access Plan	7285637337
Sprint Prescription Drug Plan	7790788849
Sprint Dental Plan	7609879755
Sprint Vision Plan	7902809053

Service Of Legal Process

Sprint Communications, Inc.
General Counsel, KSOPHF0410 - 4A353
6200 Sprint Parkway
Overland Park, KS 66251
(913)624-3000

Service of legal process may also be served on the Plan Administrator.

Benefits Contact

Most all of your benefits questions can be addressed by contacting the:

Employee Help Line (EHL)
Intranet: ehlticket **Or** **(800) 697-6000**

Plan Year

January 1 through December 31

No Guarantee Of Employment

Neither the Sprint Plans nor this Section of the Summary Plan Descriptions creates a contract of employment or a guarantee of employment between Sprint and you.

Plan Documents

The Sprint Welfare Benefits Plan can be found on i-Connect under Life & Career > Benefits. Additionally, the full Summary Plan Description for each Sprint Plan can be found on i-Connect under Life & Career > Benefits> Benefits Overview> Summary Plan Descriptions.

The benefits are subject to the full terms and conditions of the Sprint Plan documents, insurance contracts or insurance policies. These Sprint Plan documents, insurance contracts or insurance policies govern the Sprint Plans and how they are administered. If there is a discrepancy or any difference between what the *Coverage Information* Sections describe and what is written in a Sprint Plan document, insurance contract or insurance policy, the language in the Sprint Plan document, insurance contract or insurance policy governs.

Future Of The Plans

Sprint intends to continue providing benefits under the Sprint Plans, but it reserves the right to amend any Sprint Plan to change the method of providing benefits or to terminate any or all of the Sprint Plans. You will be notified of any changes.