2013 Sprint Benefits Guide

Pick what’s best for you.
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Note: This guide is designed to provide highlights of your 2013 benefits package; not every provision of each program is included. If there are any conflicts between this guide and the official plan documents, the plan documents will govern.
Total Rewards

At Sprint, our people are important to us – and you are an important part of that effort! The healthier and happier you and your co-workers are, the better you can support our customers. Benefits are available for employees, their spouses or domestic partners, and children of employees, spouses or domestic partners. Part-time employees working 20-29 hours a week are also eligible for benefits.

Sprint offers a wide range of opportunities – from world-class benefits to competitive compensation; from exceptional training and growth opportunities to a safe and invigorating work environment; from top-notch recognition programs to discounts and resources that help you even when outside the office. We care about you and your family, and one way we show this is through our Total Rewards program.

At Sprint, our Total Rewards program offers employees and their eligible dependents a number of benefit choices and services to fit their diverse lifestyles. Sprint benefits help you know that your health and finances are more secure.
Your enrollment window

Existing Employees
If you do not actively enroll in or waive certain coverage during your enrollment window, you will **automatically** receive the coverage described below for as long as your 2013 benefits remain in effect. This means that the applicable benefit deductions will be taken from your paycheck and you will not be able to enroll in any other coverage unless you have a qualifying life event (as described in Life Events section of your plan's Summary Plan Description). See the How to enroll section on page 12 for enrollment instructions.

New Hire Enrollment
If you are newly hired (or rehired more than 30 days after your prior Sprint employment ended), you may actively enroll in or waive coverage during your New Hire Enrollment window ending on the 30th calendar day after your hire/rehire date. Your benefits are effective on the **30th consecutive calendar day after your date of hire** (except for Supplemental LTD, which is effective as of the first calendar day in which you are actively at work immediately after you complete 12 months of employment). If you do not enroll or waive certain coverage during this period, you will receive the following coverage effective on the 30th calendar day after your hire/rehire date:

- **Medical/Prescription Drug:**
  - Plan: Sprint Health Account Plan
  - Coverage level: Employee only (no dependents)
  - No Healthy Living Discount

- **Life Insurance:**
  - Coverage amount: $10,000
  - Coverage level: Employee only
  - No Non-smoker Discount

Newly hired/re-hired employees will also receive information regarding enrolling in Sprint’s Voluntary Benefits programs. Voluntary Benefits are supplemental benefits programs; these plans require separate enrollment from the New Hire enrollment described above, but some do have limited enrollment windows. For more information on Sprint's Voluntary Benefit options, see The bigger picture (page 75).

How to get the most out of benefits enrollment
- Review your current and expected health care expenses. Do you have the coverage you need? Would another plan provide cost savings?
- Review this 2013 Sprint Benefits Guide and benefits information (including Summary Plan Descriptions) at i-Connect > My Life & Career > Benefits or at sprint.com/benefits.
- Review provider networks online or by phone – see the Helpful contact information chart on page 104 of this guide.
- Estimate any health care and dependent care expenses that could be funded through a Flexible Spending Account (FSA) – Not available with the Sprint Basic Plan.
- Don’t forget that your per-pay-period premiums for some benefits are based on your:
  - Tobacco/non-tobacco user status (affects Medical/Prescription Drug and Life Insurance premiums)
  - Completion of a Health Assessment at sprintalive.com by a specific deadline (affects Medical/Prescription Drug premiums)
  - Benefits Eligible Earnings: This is your annual base pay plus any targeted incentives or commissions for which you are eligible.
  - Age as of Jan. 1, 2013 (affects Life Insurance and Long-Term Disability)
- Estimate how much Life and Accidental Death & Dismemberment Insurance you and your eligible dependents might need.
Well-being

Take advantage of Sprint benefits to get and stay healthy

At Sprint, benefits enrollment is the start of an important ongoing partnership between you and the company. Our role in this partnership is to offer a broad selection of competitive benefits you and your family can use to protect your health, finances and future. We also provide the tools you need to learn about your benefits options and to responsibly get the most out of them.

That's where you come in. Your role in this partnership is to select and use your benefits wisely. Now that you have this guide open in front of you, why not take some time to learn about different plan options? Does the coverage you're about to select really meet the needs of your family? Now is the time to look and see what really works best for you and your eligible dependents.

Once you've made your selections and your 2013 benefits go into effect, your role in the partnership is more important than ever. Your ability to make educated decisions about your health care has a direct impact on the benefits Sprint can offer in the future – and these decisions have an even more direct impact on you, your well-being and your wallet. Our benefit plans are designed to give you ownership over your health care and the financial decisions related to the care you select. No matter which Sprint benefits you select, here are some actions you can take to start working towards better wellness:

• Get your annual physical exam – provided to members of Sprint Medical/Prescription Drug plans at no charge (when in-network)
• Stay active
• Eat well
• Take advantage of free Sprint resources like your personal Health Advocate (866-90-ALIVE (25483) or *545 on your Sprint phone) and GuidanceResources (888-303-3957)
• Explore health and wellness opportunities at sprintalive.com

Two great resources designed with you in mind

When it comes to health and wellness, every one of us has different strengths and challenge areas. That's why Sprint offers a variety of confidential programs designed to get and keep you healthy, regardless of your current wellness level. Sprint Alive! and GuidanceResources are two great, free resources that can provide you and your eligible dependents with support for relieving stress, eating better, staying active, quitting tobacco and a wide range of other healthy activities. Plus, you have an opportunity to earn incentives when you use some of these programs, as well. Learn more about these innovative programs on page 8.
Discounts for living a healthier life

Do you smoke or use other tobacco products? If so, then we're probably not the first ones to tell you this – but you really shouldn't! Living a tobacco-free life is not only good for your health; it also saves money on health care costs, for you, for your family and for the company. Sprint recognizes this and has designed our benefit plans accordingly by offering discounts for our Medical/Prescription Drug and Life Insurance plans related to healthy, tobacco-free lives.

Healthy Living Discount for Medical/Prescription Drug premiums

The Healthy Living Discount is a discount on your Medical/Prescription Drug paycheck premiums, ranging from about $20 to $50 per pay period depending on the level of coverage elected. To receive the Healthy Living Discount for your 2013 Medical/Prescription Drug premiums, you must select the “with Discount” option when selecting your plan, and both of the following statements must be true:

- You and all of your covered dependents must be “100% tobacco-free” as of your enrollment date, through the end of your 2013 coverage period. “100% tobacco-free” means: must never smoke nor use any tobacco or similar products and must live in a completely tobacco-free home.
- You must complete a free, confidential Health Assessment at sprintalive.com during the time period noted below. The Health Assessment generally takes about 15 to 20 minutes (not considered compensable time). The Health Assessment is also encouraged for dependents, but dependents are not required to take the Health Assessment for you to receive the Healthy Living Discount. The time period for completing your Health Assessment to receive a 2013 Healthy Living Discount is:
  - **Existing employees:** Must complete between Aug. 2 and Nov. 30, 2012
  - **Newly hired/re-hired employees and qualifying Life Events:** Must complete within 30 calendar days after your 2013 Medical/Prescription Drug coverage becomes effective

If either of these statements is not true, you will be charged the full (non-discounted) rate for your 2013 Medical/Prescription Drug plan premiums – even if you selected the “with Discount” option when enrolling. Any employees who have selected the “with Discount” option but have not taken a Health Assessment or do not meet the 100% tobacco-free requirement will be charged at the higher rate for all of their 2013 coverage period.

Non-smoker discount for Life Insurance

Sprint also offers a non-smoker discount on Employee and Spouse/Domestic Partner Life Insurance. For Sprint Life Insurance plans, a “smoker” is anyone who at any point during the 2013 coverage period uses a tobacco product such as cigars, cigarettes or chewing tobacco. For Sprint Life Insurance plans, smoker status is based upon the covered individual (employee, spouse or domestic partner), not the household. When enrolling in Employee and/or Spouse/Domestic Partner Life Insurance coverage, you must select the appropriate option based on the covered individual's smoker/non-smoker status.

Support for going tobacco- and smoke-free

If you or a covered dependent uses tobacco, there’s no time like the present to break the habit. Sprint offers a great, free tobacco-cessation program for you and/or your spouse/domestic partner through Sprint Alive!, Sprint's employee-wellness program. Using a health coach, the program provides ongoing support, including tobacco-cessation materials, goal-setting techniques and an optional eight-week supply of nicotine-replacement therapy. Existing Sprint employees are already eligible for Sprint Alive! programs, and newly hired/re-hired employees will be eligible as soon as their 2013 benefits become effective.
Employee and dependent eligibility

When enrolling in Sprint benefits, you can cover yourself and eligible members of your family (as described below). Enrolling, attempting to enroll or maintaining enrollment for ineligible persons is considered misrepresentation or fraud, which is prohibited by the Sprint benefit plans and will result in:

- immediate end of any coverage for such person retroactive to the date of the person’s ineligibility and your obligation to repay any benefits paid after that date by a Sprint plan on behalf of that person; and
- applicable employment and/or income tax consequences.

Sprint reserves the right to audit, directly or through its claims administrators and insurers, persons you have enrolled as dependents for plan eligibility at any time. Employees who are subject to such an audit will be asked to provide proof of dependent status by providing a marriage certificate, domestic-partnership certification, birth certificate, tax return, etc. You will be permitted a specified period of time to provide satisfactory proof. For more information, go to i-Connect > My Life & Career > Benefits to review Summary Plan Descriptions and Dependent Eligibility Verification Processes.

Employee eligibility

In general, if you are an employee regularly scheduled to work at least 20 hours per week, you are eligible to participate in most of Sprint’s benefit plans. Note that some of the plans and per-paycheck premium costs provided in this guide are for employees who are scheduled to work 30 or more hours per week. Where different, those per paycheck premium costs for employees working 20 to 30 hours per week are published in the online enrollment system.

Dependent eligibility

You may also cover eligible members of your family, which are your:

- **Spouse** - the opposite-sex person to whom you are legally married.
- **Domestic partner** – your same- or opposite-sex partner for so long as you both: are at least 18 years old and legally competent to consent to the domestic partner relationship; are not related to each other by blood; are in an exclusive committed relationship similar to marriage and intend to remain so indefinitely; are not married to each other or any other person; have not ended a marriage or domestic partnership with each other or any other person for at least 12 months; have resided together continuously for at least 12 months and intend to reside together indefinitely; share joint responsibility for each other's common welfare and/or financial obligations; and are not domestic partners for the sole purpose of obtaining Sprint benefits. (Note: Employees in a California HMO may also enroll an individual meeting California requirements as a Domestic Partner.)
- **Children up until age 26** – a person from live birth up to age 26 who is:
  - your, your spouse's or domestic partner’s* biological, legally adopted or step child; or
  - placed for adoption or otherwise placed by court order or placement agency (e.g., foster children, under legal guardianship) with you, your spouse or your domestic partner*; or
  - an “alternate recipient” pursuant to a Qualified Medical Child Support Order (QMCSO), as determined by the Plan Administrator.
- **Disabled children** – your, your spouse's or your domestic partner’s* biological or legally adopted child who was covered under a Sprint benefit plan immediately prior to age 26 and who is permanently and totally disabled.

* Domestic partner children may be enrolled only if the domestic partner is also enrolled.

Eligibility for families with more than one Sprint employee

- You cannot be covered as both a Sprint employee and the dependent of a Sprint employee under the Medical/Prescription Drug, Dental or Vision plans
- None of your dependents can be covered by both you and another Sprint employee under the Medical/Prescription Drug, Dental or Vision plans
- You may be insured as both an employee and the spouse/qualified domestic partner of an employee under the Employee and Spouse/Domestic Partner Life Insurance plans
- If both you and your spouse/qualified domestic partner are Sprint employees, you both may elect Dependent Life Insurance for the same eligible dependent children you both may elect Dependent Life Insurance for the same eligible dependent children
How to enroll

**Step one – Enter the enrollment system**

A. Open i-Connect

B. Launch PeopleSoft Employee Self Service (from the i-Connect home page, click on Employee Self Service (ESS) > Launch Employee Self Service)

C. Click Benefits > Benefits Enrollment > Select to see your Enrollment Summary page
   - You will see a list of the benefits and their per-paycheck premium costs that you will be enrolled in (and pay for) in 2013. You may now make changes to these elections if you wish.
   - For Annual Enrollment users – Once you have reached this screen, you **must** actively elect a 2013 Medical/Prescription Drug plan, even if you wish to remain in the same plan you had in 2013; if you do not, you may be defaulted to a non-preferred plan.

**Step two – Make your benefit elections**

A. Click the **Edit** box next to any benefit you wish to elect or change.
   - If you select your Medical/Prescription Drug plan as the benefit you would like to change, you will be required to certify that you understand the requirements for the 2013 Healthy Living Discount (even if you do not intend to sign up for discounted rates). Additional details about the Healthy Living Discount can be found on page 8.
   - If the benefit allows you to cover eligible dependents, you will see an Enroll Your Dependents section at the bottom of the page. Refer to the on-screen instructions for specific information for enrolling dependents.

**Step three – final review and submission of benefit elections and dependents**

A. Before you submit your elections, carefully review your Enrollment Summary page to ensure you are enrolled in the coverage you want. See something you’d like to change? Now’s your chance. Remember – unless you have a qualifying life event, these elections will be binding for all of 2013. It is strongly recommended that you save to your desktop and/or print a copy of this page.

B. Scroll to the bottom of your Enrollment Summary page and click **Submit** a first time.

C. Click **Submit** a second time to authorize your elections and electronic signature.
   - If you aren’t quite ready to finalize your 2013 benefit elections, you can click Cancel to return to the Enrollment Summary page.

D. If your enrollment was successfully submitted, you will see a confirmation page. Click **OK** when finished.

**Step four – completing your enrollment**

A. It is your responsibility to ensure that your recorded enrollment is what you intended and that all information is correct. To do this, at least one business day after you submit your benefit elections, log onto i-Connect > PeopleSoft Employee Self Service > Benefits > Benefits Summary. In the date box, enter the date when your 2013 benefits are to become effective (01/01/2013 for current Sprint employees or 30 days after hire/re-hire date for newly hired/re-hired employees). Then, click **GO** to review your benefit elections.

- Enrolling a new dependent? You may be contacted after your enrollment to provide documentation to confirm your dependent’s eligibility. Make sure all of your covered dependents meet Sprint’s eligibility requirements as described on page 11.

- **Important:** Make sure each dependent you want covered under a benefit has a check mark next to his or her name!

   - If you enroll in the Sprint Basic Plan, you will be given the option of contributing to a Health Savings Account (HSA). Your HSA contributions will be made via payroll pre-tax deductions over the course of the year. If you elect to contribute to an HSA, note that you must still set up your HSA with ACS|BNY Mellon Bank as described on page 25.

C. Once you have updated your benefit elections, enrolled your dependents (if applicable) and provided any additional information (such as beneficiaries for Life Insurance), click **Update Elections** to see a confirmation page for this benefit option enrollment.

D. After you carefully review the information on your confirmation page, click **Update Elections** to return to your main Enrollment Summary screen

E. Repeat this process for each benefit you want to change.
After you enroll

Depending on the elections you make, you may receive forms for completion (in order to finalize your enrollment) and/or ID cards. In addition, you may have questions about if and when you can make changes to your elections. Read below for additional information.

Complete forms

If you elected Employee Life Insurance for yourself and/or Dependent Life Insurance for your spouse/domestic partner and these elections require evidence of insurability, you will be contacted by Sprint's Life Insurance carrier by mail with instructions on completing a Personal Health Application. If you are a current Sprint employee making these elections during the regular Annual Enrollment window, you should receive the details in January 2013. If you are enrolling as a newly hired/re-hired employee or as the result of a qualifying life event, you should receive these details within a few weeks after your enrollment.

ID and debit cards

Sprint's Medical/Prescription Drug, Dental and Vision plans all come with ID cards. For 2013, employees will receive two separate cards for their Medical/Prescription Drug plan – one for medical coverage and one for prescription drug coverage. When you go to your provider's office, be sure to show your ID card.

• Current Sprint employees enrolling during the regular Annual Enrollment window should receive any new cards before Jan. 1, 2013.
• Employees enrolling as a new hire or re-hire or following a qualifying life event should receive any required ID cards approximately two weeks after enrolling.

Sprint’s Health Care Flexible Spending Account comes with a debit card that you can use to pay for eligible health care expenses with Flexible Spending Account funds. All employees who enroll in a Health Care Flexible Spending Account for 2013 will receive a new card. Note that this only applies to Health Care Flexible Spending Accounts; federal rules do not permit use of debit cards for dependent-care expenses through a Dependent Care Flexible Spending Account.

When you receive any ID cards, please make sure all information on them is correct, and always carry your card(s) with you in case of an emergency.

Changing your elections during the year

Your benefits elections are binding until Dec. 31, 2013, except for changes allowable or required in connection with a qualifying life or employment event. These are changes in your family such as birth, adoption, marriage, divorce, death of a dependent, or change in employment status of you or your spouse/domestic partner. As a general rule, if you have a qualifying life or employment event that impacts your benefit needs, you must make a request for changes no later than the 30th calendar day after the event.

For full details regarding qualifying life and employment events, how to make changes to your benefits and your beneficiary designations outside of your normal enrollment period, and the dates when benefits changed during the year will become effective, go to i-Connect > My Life & Career > Benefits.
Costs: Your per-paycheck premium costs

This section of the guide shows the per-paycheck premium costs for your 2013 benefits that are taken out of 24 paychecks during the calendar year. (Note that Sprint will have 26 pay periods during 2013 but these benefit premiums will be taken out only 24 times – the first and second regular payroll dates of each month.)

All costs are also available when you log in to the online enrollment system via Employee Self Service to select your 2013 benefits (see the How to enroll section of this guide beginning on page 12).

Benefits Eligible Earnings

“Benefits Eligible Earnings” is defined as your annual base pay plus any targeted incentives or commissions for which you are eligible. Your Benefits Eligible Earnings amount is used to determine the premiums you will pay for Medical/Prescription Drug coverage, Life Insurance, Accidental Death & Dismemberment Insurance and Supplemental Long-Term Disability.

Special note for part-time employees

The following price charts for Medical/Prescription Drug and Dental coverage show plan costs for employees scheduled to work 30 or more hours per week. If you’re scheduled for 20-29 hours per week, you can find your costs online when you make your benefit elections (see the How to enroll section of this guide beginning on page 12).

Special note regarding domestic-partner costs

Costs for Medical/Prescription Drug, Dental and Vision coverage for qualified domestic partners and domestic partners’ child(ren) may differ from those listed. These costs are after-tax and can be found online when you select your 2013 benefits. Also, the employer-provided cost of your domestic partner’s coverage is considered taxable income. You will be subject to the resulting federal, state, local and FICA tax withholdings.

Waive Medical/Prescription Drug Coverage

When you waive Sprint Medical/Prescription Drug coverage, you receive an annual credit of $600 (prorated for newly hired/re-hired employees based on when benefit eligibility starts) to help purchase other benefits.

Medical/Prescription Drug premium costs

Individual per-paycheck deductions for Medical/Prescription Drug plans are based on your Benefits Eligible Earnings. These deductions are withheld before taxes except in cases for domestic partner dependent coverage.

To use this chart, find your Benefits Eligible Earnings column and look at the appropriate cost for the Sprint Basic Plan, Sprint Health Account Plan, the Sprint Consumer Access Plan, Kaiser regional plans and the TRICARE Supplement Plan.
### Full-time employees' Medical/Prescription Drug per-paycheck premium rates for 2013

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<th>Premiums without Healthy Living Discount</th>
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<tr>
<td></td>
<td>$100.20</td>
<td>$181.19</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$122.95</td>
<td>$212.23</td>
</tr>
<tr>
<td></td>
<td>$162.12</td>
<td>$234.90</td>
</tr>
<tr>
<td></td>
<td>$191.10</td>
<td>$266.25</td>
</tr>
<tr>
<td></td>
<td>$229.74</td>
<td>$334.90</td>
</tr>
<tr>
<td>Kaiser Permanente (Southern California)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$21.35</td>
<td>$36.02</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$48.32</td>
<td>$50.62</td>
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<tr>
<td>Employee + Child(ren)</td>
<td>$42.23</td>
<td>$59.12</td>
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<tr>
<td>Employee + Family</td>
<td>$74.77</td>
<td>$69.83</td>
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<tr>
<td></td>
<td>$100.92</td>
<td>$97.07</td>
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<td>$113.71</td>
<td>$157.98</td>
</tr>
<tr>
<td></td>
<td>$138.64</td>
<td>$183.77</td>
</tr>
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</table>
## 2013 Medical/Prescription Drug per-paycheck premiums (costs for full-time employees)

<table>
<thead>
<tr>
<th>Benefits Eligible Earnings</th>
<th>Premiums with Healthy Living Discount</th>
<th>Premiums without Healthy Living Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; $40,000</td>
<td>$40,000 – $69,999</td>
</tr>
<tr>
<td><strong>Kaiser Permanente (Colorado)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$30.46</td>
<td>$42.19</td>
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<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$69.08</td>
<td>$95.15</td>
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<tr>
<td>Employee + Child(ren)</td>
<td>$66.55</td>
<td>$88.94</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$106.68</td>
<td>$143.98</td>
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<tr>
<td><strong>Kaiser Permanente (Georgia)</strong></td>
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<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$31.94</td>
<td>$44.24</td>
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<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$70.55</td>
<td>$97.17</td>
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<tr>
<td>Employee + Child(ren)</td>
<td>$67.79</td>
<td>$90.60</td>
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<tr>
<td>Employee + Family</td>
<td>$130.87</td>
<td>$170.04</td>
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<td><strong>Kaiser Permanente (Hawaii)</strong></td>
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<tr>
<td>Employee + Child(ren)</td>
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<td>Employee + Family</td>
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<td>$77.58</td>
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<tr>
<td><strong>Kaiser Permanente (Mid-Atlantic)</strong></td>
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</tr>
<tr>
<td>Employee Only</td>
<td>$29.83</td>
<td>$41.32</td>
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<tr>
<td>Employee + Spouse/Domestic Partner</td>
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<td>$93.02</td>
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<td>Employee + Child(ren)</td>
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<td>Employee + Family</td>
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<td><strong>TriCare</strong></td>
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<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$33.50</td>
<td>$33.50</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$66.00</td>
<td>$66.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$66.00</td>
<td>$66.00</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$89.00</td>
<td>$89.00</td>
</tr>
</tbody>
</table>
**Dental per-paycheck premium costs**

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Cost per plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic Dental Plan</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$1.68</td>
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<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$4.00</td>
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<td>Employee + Child(ren)</td>
<td>$4.05</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$6.53</td>
</tr>
</tbody>
</table>

* Pricing for employees scheduled to work 30 or more hours per week.

**Vision per-paycheck premium costs**

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$1.41</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$3.59</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$6.82</td>
</tr>
</tbody>
</table>

* Pricing for employees scheduled to work 30 or more hours per week.

**Life Insurance per-paycheck premium costs**

Your per-pay-period premiums for Employee Life Insurance are based on your Benefits Eligible Earnings, your age, your smoker/non-smoker status and the amount of coverage you elect. Dependent Life Insurance costs for your spouse/domestic partner are based on age, smoker/non-smoker status and the amount of coverage elected. Deductions for both Employee Life Insurance and Dependent Life Insurance are taken after-tax. Please see the online benefits enrollment system for your specific costs.

The after-tax deductions for Child Life Insurance are as follows:

<table>
<thead>
<tr>
<th>Coverage amount*</th>
<th>Cost per pay period</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$0.29</td>
</tr>
<tr>
<td>$10,000</td>
<td>$0.58</td>
</tr>
<tr>
<td>$20,000</td>
<td>$1.15</td>
</tr>
</tbody>
</table>

* The Child Life Insurance per-paycheck premium deduction is the same if covering one child or multiple children.

**Accidental Death & Dismemberment Insurance per-paycheck premium costs (pre-tax)**

Your pre-tax premiums are based on your Benefits Eligible Earnings and the level of coverage you elect. Please see the online benefits enrollment system for your specific costs.

**Disability before-tax per-paycheck premium costs**

<table>
<thead>
<tr>
<th>Disability Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term</td>
<td>No employee premium required; coverage paid for entirely by Sprint.</td>
</tr>
<tr>
<td>Long-Term</td>
<td>50% coverage level paid for entirely by Sprint. LTD before-tax premium costs for higher coverage levels (55%, 60% and 65%) are based on your age, Benefits Eligible Earnings and the level of coverage you elect. See the online enrollment system for your specific costs.</td>
</tr>
</tbody>
</table>

**Group Legal Services before-tax per-paycheck premium costs**

The after-tax cost of Group Legal Services is $8.45 per pay period.
A closer look

When it comes to choosing your benefits, only you know what you want and need. Look through the remaining pages of this guide to get familiar with your options. It will be time well spent!

Remember that this guide provides a general overview of your benefits. For a more detailed view, please read the Summary Plan Descriptions and Summaries of Benefit Coverage at i-Connect > My Life & Career > Benefits.

Medical/Prescription Drug

Sprint’s health plans include both medical and prescription drug coverage. The plans are designed to fit a variety of needs, meaning that there’s a plan out there that’s best for you!

Your 2013 Medical/Prescription Drug plan choices:

- Sprint Basic Plan – available nationwide and administered by BlueCross BlueShield of Illinois – Now compatible with a Health Savings Account (HSA)
- Sprint Health Account Plan – available nationwide and administered by UnitedHealthcare
- Sprint Consumer Access Plan – available nationally and administered by BlueCross BlueShield of Illinois
- Health Maintenance Organizations (HMOs) – available in some regions and administered by Kaiser Permanente
- TRICARE Supplement Plan – available for retired military and spouses of retired military who are enrolled in the Department of Defense’s TRICARE plan

Below is a high-level overview of these options. Please see the Medical/Prescription Drug Plan Comparison Chart on page 34 for more details.

The Sprint Basic Plan – Now compatible with a Health Savings Account (HSA)

The Sprint Basic plan offers you…

- A network of doctors, hospitals and other professionals to provide network benefits plus the ability to go out-of-network (at a higher cost to you)
- Annual network medical/prescription drug deductible of $1,750 (employee-only coverage) and $3,500 (family coverage tiers). You must meet your coverage level’s full deductible before the plan begins paying co-insurance for medical or prescription drug expenses. The following expenses will receive a benefit from the plan even if the deductible is not yet met:
  - Network preventive care as defined by the U.S. Preventive Services Task Force guidelines (like annual physical exams and immunizations) paid at 100%
  - Certain network preventive prescription drugs (as defined by the plan) are not subject to the deductible and are therefore paid at regular co-insurance rate
- The option of contributing to a Health Savings Account (HSA) to use for qualifying eligible medical, prescription drug, dental and vision expenses. You can elect to make payroll-deduction contributions to your HSA on a pre-tax basis. You can modify the contributions at any time during the year. In addition, if you make HSA contributions of at least $24 per plan year, you will receive total annual contributions from Sprint in the following amounts (your contributions and Sprint’s must be divided equally across each of the paychecks from which you make your 2013 contribution):
  - $500/year HSA contribution for employee-only coverage (prorated for partial-year enrollment)
  - $1,000/year HSA contribution for family coverage tiers (prorated for partial-year enrollment)

Important: HSAs are subject to specific federal rules. If you enroll in the Sprint Basic Plan (and, in particular, if you open and fund an HSA), it is your responsibility to know and abide by these rules. Additional details can be found on page 46.

- After the medical/prescription drug deductible is met, you pay co-insurance for covered medical and prescription drug expenses
  - Co-insurance: 20% of total cost for most in-network inpatient/outpatient services (plan pays 80%)
  - Emergency-room visits: you pay a 20% share for true emergency situations. You pay a 40% share for non-emergency situations.
- Prescription drug coverage administered by CVS Caremark paid at 80% for 30- and 90-day supplies via retail and mail-order network pharmacies (after full medical/prescription deductible has been met, except for eligible preventive drugs)
- Once you have met your Out-of-Pocket Limit, the plan pays eligible medical and prescription drug expenses at 100%.
The Sprint Health Account Plan

The Sprint Health Account Plan offers you …

• A network of doctors, hospitals and other professionals to provide network benefits plus the ability to go out-of-network (at a higher cost to you)
  - Network preventive care as defined by the U.S. Preventive Services Task Force guidelines (like annual physical exams and immunizations) paid at 100%

• Annual network medical/prescription drug deductible of $1,600 (employee-only coverage) and $3,200 (family coverage tiers). You must meet your coverage level’s full deductible before the plan begins paying co-insurance for medical or prescription drug expenses. The following expenses will receive a benefit from the plan even if the deductible is not yet met:
  - Network preventive care as defined by the U.S. Preventive Services Task Force guidelines (like annual physical exams and immunizations) paid at 100%
  - Certain network preventive prescription drugs (as defined by the plan) are not subject to the deductible and are therefore paid at regular co-insurance rate

• An annual Health Reimbursement Account (HRA) to use for eligible medical and prescription drug expenses (unused funds can be carried over to the next year up to the annual maximum), which amounts to more than half of your deductible and is used towards your deductible
  - $800/year HRA contribution for employee-only coverage (prorated for partial-year enrollment)
  - $1,600/year HRA contribution for family coverage tiers (prorated for partial-year enrollment)
  - Additional HRA credit of $400 for employees, spouses and domestic partners who complete Sprint Alive! Diabetes program requirements, up to $800 maximum per family

• After the medical/prescription deductible is met, you pay co-insurance for medical and prescription drug expenses
  - Co-insurance: 20% of total cost for most in-network inpatient/outpatient services (plan pays 80%)
  - Emergency-room visits: you pay a 20% share after co-pay for true emergency situations. You pay a 40% share after co-pay for non-emergency situations.

- In select areas, access to a High Performance Network (HPN) of specialists who’ve demonstrated themselves as more effective in providing better outcomes for patients while keeping costs down may be available. If you choose to use an HPN specialist, the plan pays 85% of those expenses, while you pay 15%. HPN specialists are listed in the plan’s directory of providers and may include specialties such as cardiology, general surgery and orthopedics.

• Prescription drug coverage administered by CVS Caremark paid at 80% for 30- and 90-day supplies via retail and mail-order network pharmacies (after full medical/prescription deductible has been met, except for eligible preventive drugs, as noted above)

• Once you have met your Out-of-Pocket Limit, the plan pays eligible medical and prescription drug expenses at 100%.

Sprint Consumer Access Plan

The Sprint Consumer Access Plan offers you …

• A network of doctors, hospitals and other professionals to provide network benefits plus the ability to go out-of-network (at a higher cost to you)

• Annual network medical deductible of $750 (employee-only coverage) and $1,500 (family coverage tiers). You must meet your coverage level’s full deductible before the plan begins paying co-insurance for medical expenses. The following expenses are not subject to the medical deductible:
  - Network preventive care as defined by the U.S. Preventive Services Task Force guidelines (like annual physical exams and immunizations) paid at 100%

• After the medical deductible is met, you pay co-pay and/or co-insurance for covered medical expenses
  - Co-insurance: 15% of total cost for most in-network inpatient/outpatient services (plan pays 85%)
  - Emergency-room visits: you pay a 15% share after co-pay for true emergency situations. You pay a 40% share after co-pay for non-emergency situations.

• Once you have met your Out-of-Pocket Limit, the plan pays eligible medical expenses at 100%. Co-pays do not count towards the out-of-pocket limit.

• Prescription drug coverage offering co-pay and co-insurance benefits for 30- and 90-day supplies via retail and mail-order pharmacies administered by CVS Caremark (after prescription drug deductible is met, except for certain eligible preventive prescription drugs, as defined by the plan). Please refer to the Sprint Consumer Access Plan Prescription Drug chart on page 48 for more details.
Health Maintenance Organizations (HMOs)

A Health Maintenance Organization (HMO) is a medical plan that pays benefits only when you use its network of doctors and facilities. In select areas, Sprint offers employees the opportunity to enroll in an HMO. All HMOs are different, but in general, these plans offer you:

• A network of doctors, hospitals and other professionals to provide network-only benefits
• Annual in-network medical deductible of $750 (employee-only coverage) and $1,500 (family coverage tiers). You must meet your coverage level’s full deductible before the plan begins paying co-insurance for medical expenses. The following expenses are not subject to the medical deductible:
  - Network preventive care as defined by the U.S. Preventive Services Task Force guidelines (like annual physical exams and immunizations) paid at 100%
  - After deductible met, you pay co-pay and/or co-insurance
    - Co-pay: flat fee for some office visits
    - Co-insurance: 20% of total cost for some office visits and most inpatient/outpatient services (plan pays 80%)
• Once you have met your Out-of-Pocket Limit, the plan pays eligible expenses at 100%.
• No benefits for non-network providers, except for emergencies
• Prescription drug coverage offering co-pay benefits for 30- and 90-day supplies via retail and mail-order pharmacies through Kaiser Permanente participating pharmacies.
• All HMOs are different, so for more information on the specific medical and prescription services available through an HMO in your area, be sure to refer to your HMO’s Summary Benefit Coverage on i-Connect > My Life & Career > Benefits.

TRICARE Supplement Plan

For retired military and spouses of retired military who are part of the Department of Defense’s TRICARE benefits plan

The TRICARE Supplement Plan is designed to coordinate with TRICARE, the Department of Defense’s health benefit program for the military community. To enroll in the TRICARE Supplement Plan through Sprint, an employee must first be eligible for the main TRICARE plan through the Department of Defense. Together, TRICARE and the TRICARE Supplement Plan provide comprehensive health coverage with the freedom to use any TRICARE or Medicare-authorized civilian provider.

The TRICARE Supplement Plan is offered to Sprint employees via convenient pre-tax payroll deductions. The TRICARE Supplement is fully funded by the employee (no Sprint subsidy), and there is no Healthy Living Discount on premiums.

The TRICARE Supplement Plan option is available only to Sprint employees under the age of 65 who have retired from the military or are spouses/surviving spouses of retired military personnel. **Note: the TRICARE Supplement Plan has different eligibility requirements for dependents from Sprint’s other Medical/Prescription Drug plans.** For additional information about the TRICARE Supplement Plan, including dependent-eligibility requirements, call ASI, administrator for the TRICARE Supplement Plan, toll-free at 800-638-2610, ext. 255, or visit asicorporation.com.

Waive Medical/Prescription Drug Coverage

If you’re covered by another employer-provided group health plan or federal- or state-funded health plan, you can waive Sprint Medical/Prescription Drug coverage. To waive, simply elect Waive Coverage. When you waive Sprint Medical/Prescription Drug coverage, you receive an annual credit of $600 (prorated for newly hired/re-hired employees based on when benefit eligibility starts) to help purchase other benefits. Any part of that amount not used to purchase other benefits will be paid to you as taxable income over the course of the calendar year.
Medical terms

Allowable charges: When you use non-network providers, your plan has no way of regulating what the doctor or facility charges, so there are charge limits on how much of the providers’ fees the plan will cover. Generally, these limits are based on Medicare allowances for comparable services. You may get a bill from a non-network provider for additional amounts not paid by your plan. Allowable-charge limits do not apply to HMO charges (all of which are required to be network) or network charges for Sprint’s three national plans.

Deductible: A deductible is the amount of money you pay for expenses each year before your plan begins paying benefits. Note that many preventive, in-network medical expenses are not subject to deductible. Deductibles are handled slightly differently depending on your plan:

- **Sprint Basic Plan and Sprint Health Account Plan:** Under these plans, your annual deductible is met with both medical and prescription drug expenses. If you have employee-only coverage, the plan begins paying as soon as your individual 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). Note that even if your deductible has not been met, your plan will still pay a benefit for eligible network preventive medical services (covered at 100%) and eligible network preventive prescription drugs (covered at regular co-insurance rate).

- **Sprint Consumer Access Plan:** Under this plan, your annual medical deductible is met with only medical (no prescription drug) expenses. If you have employee-only coverage, the plan begins paying as soon as your individual 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). Note that even if your deductible has not been met, your plan will still pay a benefit for eligible network preventive medical services (covered at 100%). This plan has a separate prescription drug deductible for non-preventive, non-specialty drugs.

- **HMOs:** Your annual deductible is met with only medical (no prescription drug) expenses. If you have employee-only coverage, the plan begins paying as soon as your individual deductible is met. If you have a family coverage tier, the plan begins paying for any individual family member once the individual deductible has been met for that family member. The plan begins paying eligible expenses for all family members once two or more family members meet their individual deductibles or when all of the family members’ combined eligible expenses meet the family deductible amount. Note that even if your deductible has not been met, your plan will still pay a benefit for eligible network preventive medical services (covered at 100%). These plans also provide prescription drug coverage offering co-pay benefits for 30- and 90-day supplies via retail and mail-order pharmacies through Kaiser Permanente participating pharmacies.

Health Reimbursement Account (HRA): An annual fund of money that Sprint provides for the Sprint Consumer Access Plan and Sprint Health Account Plan for members to use toward eligible expenses. “Eligible expenses” include medical charges for Sprint Consumer Access Plan members and both medical and prescription drug charges for Sprint Health Account Plan members. The HRA provides “first dollar” coverage for eligible expenses, giving members access to the funds as soon as coverage begins. Unused funds up to a pre-set maximum roll over to the next year.

Health Savings Account (HSA): A savings account that Sprint Basic Plan members may optionally fund. Those who do so at the minimum amount will receive additional funding in the account from Sprint. HSA funds can be used for eligible out-of-pocket medical, prescription drug, dental and vision expenses. Unused HSA funds remain in your account from year to year and are retained if you enroll in a different plan or leave Sprint. HSAs are subject to specific federal regulations, which are described more on page 46.

High Performance Network (HPN): A smaller network of specialty doctors set up by the Sprint Health Account Plan to help keep costs down without sacrificing quality of care for you. HPNs are only available in select areas, so refer to your Benefits Summary Sheet at i-Connect > My Life & Career > Benefits for information on how to find providers online.

Network: Providers, facilities and supplies that are covered as part of your plan’s network. Eligible network expenses are generally paid by the plan at a higher co-insurance amount (after deductible is met). Sometimes known as “in-network.”

Non-network: Providers, facilities and supplies that are not covered as part of your plan's network. Eligible non-network expenses are generally paid by the plan at a lower co-insurance amount of the plan’s allowable-charges limit (after deductible is met). Sometimes known as “out-of-network.”

Out-of-Pocket Limit: Protects members from overwhelming costs by setting up a maximum amount that a member will have to pay in a given year for eligible expenses. Once the Out-of-Pocket Limit has been met, the plan will pay 100% of eligible expenses for the remainder of the year of the deductible. The costs paid by you which count toward your Out-of-Pocket Limit vary for each plan.
**Prescription Drug terms**

**90-day Fill Program:** A 90-day Fill Program requires you to obtain a 90-day supply of maintenance drugs. Maintenance drugs are those that are typically used for chronic conditions or disease prevention. Some examples include cholesterol-lowering medication; diabetic therapies; hormonal supplements; and medicines to treat/manage blood pressure, heart disease and glaucoma.

**Formulary:** A formulary is a preferred listing of FDA-approved drugs selected for use by the benefit provider based on quality and cost-effectiveness. Formulary listings are periodically reviewed and updated, so be sure your doctor is aware of your plan’s formulary to avoid overpaying.

**Generic Equivalent Drugs:** Generic medications are FDA-approved versions of brand-name drugs. Once legal rights to brand names expire, drug manufacturers can create generic versions. The generic versions are sold at reduced prices but match their brand-name counterparts’ therapeutic standards.

**Prior Authorization:** Certain medications require prior authorization in accordance with medical criteria or guidelines approved by the Food and Drug Administration or the drug manufacturer.

**Specialty Drugs and Specialty Pharmacy:** Certain high-cost injectable medications and selected oral drugs designed to treat chronic, often complex, diseases are called Specialty Drugs. Examples include drugs to treat multiple sclerosis, cancer, rheumatoid arthritis, hepatitis B & C and human growth deficiency. See your plan’s Summary Plan Description or Summary of Benefit Coverage at i-Connect > My Life and Career > Benefits for specific information about how Specialty Pharmacy purchases work for your plan.

**Supply Limits:** Certain medications are subject to quantity-level limits in accordance with plan medical criteria or guidelines approved by the Food and Drug Administration or the drug manufacturer.

**Step Therapy:** The Step Therapy program requires you to first try a well-established, generally inexpensive treatment that is known to be safe and effective for most people. This is referred to as a first-line drug. If your prescription is subject to Step Therapy requirements, CVS Caremark will alert the pharmacist. If this occurs, you will need to either switch to a first-line drug or have your physician contact CVS Caremark for information on how to obtain approval for a second-line drug. Step Therapy applies to, but is not limited to, drugs for insomnia, pain, cholesterol and osteoporosis.
Medical/Prescription Drug coverage levels

When you enroll in Medical/Prescription Drug coverage, you will be able to sign up for one of four coverage levels depending on which eligible dependents you cover:

- Employee Only
- Employee + Spouse/Domestic Partner
- Employee + Child(ren)
- Employee + Family

About Medical/Prescription Drug premium costs

Your before-tax per-paycheck premium costs for Medical/Prescription Drug coverage are based on the plan you select as well as your Benefits Eligible Earnings, dependent-coverage level and Healthy Living Discount status. These costs can be found in the Costs section of this guide, which begins on page 18.

The details… Medical/Prescription Drug plans

Note: HMO availability and coverage varies by region. For information more information on HMOs, please visit i-Connect > My Life & Career > Benefits.

The details… National Medical/Prescription Drug plans

<table>
<thead>
<tr>
<th>Features</th>
<th>Sprint Basic Plan</th>
<th>Sprint Health Account Plan</th>
<th>Sprint Consumer Access Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical coverage claims administrator</td>
<td>BlueCross BlueShield of Illinois</td>
<td>UnitedHealthcare</td>
<td>BlueCross BlueShield of Illinois</td>
</tr>
<tr>
<td>Per-paycheck premiums</td>
<td>Lowest</td>
<td>Medium</td>
<td>Highest</td>
</tr>
<tr>
<td>Expected out-of-pocket costs</td>
<td>Highest</td>
<td>Medium</td>
<td>Lowest</td>
</tr>
<tr>
<td>Network/Out-of-network</td>
<td>Network</td>
<td>Non-network</td>
<td>Network</td>
</tr>
<tr>
<td>Choice of doctor/facility</td>
<td>May use any doctor/facility; however, plan pays higher benefits with network providers</td>
<td>May use any doctor/facility; however, plan pays higher benefits with network providers</td>
<td>May use any doctor/facility; however, plan pays higher benefits with network providers</td>
</tr>
<tr>
<td>For preventive medical services, plan generally pays…</td>
<td>100% even if deductible not met (examples: well-child visits up to age 6 and adult screenings as defined in the Summary Plan Description)</td>
<td>Routine physical exams, well-child visits through age 5 and preventive screenings for adults covered at 60% co-insurance of allowable charges (after deductible met); other services not covered</td>
<td>Routine physical exams, well-child visits through age 5 and preventive screenings for adults covered at 60% co-insurance of allowable charges (after deductible met); other services not covered</td>
</tr>
</tbody>
</table>

For preventive medical services, plan generally pays…

- 100% even if deductible not met (examples: well-child visits up to age 6 and adult screenings as defined in the Summary Plan Description)
- Routine physical exams, well-child visits through age 5 and preventive screenings for adults covered at 60% co-insurance of allowable charges (after deductible met); other services not covered
- 100% even if deductible not met (examples: well-child visits up to age 6 and adult screenings as defined in the Summary Plan Description)
- Routine physical exams, well-child visits through age 5 and preventive screenings for adults covered at 60% co-insurance of allowable charges (after deductible met); other services not covered
<table>
<thead>
<tr>
<th>Features</th>
<th>Sprint Basic Plan</th>
<th>Sprint Health Account Plan</th>
<th>Sprint Consumer Access Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical coverage claims administrator</td>
<td>BlueCross BlueShield of Illinois</td>
<td>UnitedHealthcare</td>
<td>BlueCross BlueShield of Illinois</td>
</tr>
<tr>
<td>Per-paycheck premiums</td>
<td>Lowest</td>
<td>Medium</td>
<td>Highest</td>
</tr>
<tr>
<td>Expected out-of-pocket costs</td>
<td>Highest</td>
<td>Medium</td>
<td>Lowest</td>
</tr>
<tr>
<td>Network/Out-of-network</td>
<td>Network</td>
<td>Non-network</td>
<td>Network</td>
</tr>
<tr>
<td>Health Reimbursement Account (HRA)</td>
<td>Not Available with Sprint Basic Plan</td>
<td>Funded 100% by Sprint, your HRA pays for eligible medical and prescription drug expenses before you pay anything out of pocket. <strong>Funded amount (pro-rated for partial-year enrollment)</strong> $800/employee-only coverage (plus any carryover HRA funds from prior year) $1,600/family coverage tiers (plus any carryover HRA funds from prior year) (If you enroll during the plan year, these funds will be pro-rated based on remaining months of the year) Additional HRA credit of $400 for employees, spouses and domestic partners who complete Sprint Alive! Diabetes program requirements (up to $800 maximum per family – call 866-90-ALIVE to learn more)</td>
<td>Funded 100% by Sprint, your HRA pays for eligible medical expenses before you pay anything out of pocket. <strong>Funded amount (pro-rated for partial-year enrollment)</strong> $300/employee-only coverage $600/family coverage tiers (If you enroll during the plan year, these funds will be pro-rated based on remaining months of the year)</td>
</tr>
<tr>
<td>Health Savings Account (HSA)</td>
<td>A tax-exempt savings account, which may be opened by employees enrolled in a designated High Deductible Health Plan, such as the Sprint Basic Plan. Employees who open an HSA and contribute at least $24 (spread out equally over their 2013 paychecks) will receive additional funding from Sprint (provided in equal increments across 2013 paychecks and pro-rated for partial-year enrollment): $500/employee-only coverage $1,000/family coverage tiers Members’ 2013 maximum contributions from all sources (Sprint’s contributions plus member’s contributions) is: $3,250/employee-only coverage $6,450/family coverage tiers (Employees age 55 or older in 2013 may make an additional “catch up” contribution of up to $1,000.) Remaining HSA funds may be used even if you are no longer in the Sprint Basic Plan or a Sprint employee. HSAs are subject to federal regulations; see HSAs: The Rules (page 46) for details</td>
<td>Not available with Sprint Health Account Plan</td>
<td>Not available with Sprint Consumer Access Plan</td>
</tr>
<tr>
<td>Features</td>
<td>Sprint Basic Plan</td>
<td>Sprint Health Account Plan</td>
<td>Sprint Consumer Access Plan</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>----------------------------------------</td>
</tr>
<tr>
<td>Medical coverage claims administrator</td>
<td>BlueCross BlueShield of Illinois</td>
<td>UnitedHealthcare</td>
<td>BlueCross BlueShield of Illinois</td>
</tr>
<tr>
<td>Per-paycheck premiums</td>
<td>Lowest</td>
<td>Medium</td>
<td>Highest</td>
</tr>
<tr>
<td>Expected out-of-pocket costs</td>
<td>Highest</td>
<td>Medium</td>
<td>Lowest</td>
</tr>
<tr>
<td>Network/Out-of-network</td>
<td>Network</td>
<td>Non-network</td>
<td>Network</td>
</tr>
<tr>
<td>Annual carryover maximum for plan’s health-funding account (HSA or HRA)</td>
<td>No carryover maximum for Health Savings Account</td>
<td>From 2013 to 2014, the maximum amount you can carry over from year to year in the Sprint Health Account Plan’s Health Savings Account is: $3,000/Individual $6,000/Family</td>
<td>From 2013 to 2014, the maximum amount you can carry over from year to year in the Sprint Consumer Access Plan’s Health Reimbursement Account is: $2,000/Individual $4,000/Family</td>
</tr>
<tr>
<td>Annual deductible</td>
<td>$1,750/Individual $3,500/Family</td>
<td>$1,600/Individual $3,200/Family</td>
<td>$750/Individual $1,500/Family</td>
</tr>
<tr>
<td>Individual or Family deductible?</td>
<td>Individual deductible applies only for employee-only coverage</td>
<td>If enrolled in any coverage level covering dependents, the Family deductible must be met before co-insurance benefits apply</td>
<td>HRA and HSA funds may be used to satisfy a portion of the deductible</td>
</tr>
<tr>
<td>Deductible applies to…</td>
<td>Eligible medical and prescription drug expenses</td>
<td>Eligible medical and prescription drug expenses</td>
<td>Eligible medical expenses (separate prescription drug deductible – see chart on page 48)</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit</td>
<td>$4,000/Individual $8,000/Family</td>
<td>$3,000/Individual $6,000/Family</td>
<td>$2,000/Individual $4,000/Family</td>
</tr>
<tr>
<td>Out-of-Pocket Limit applies to…</td>
<td>Eligible medical and prescription expenses</td>
<td>Eligible medical and prescription drug expenses</td>
<td>Eligible medical (not prescription drug) expenses</td>
</tr>
<tr>
<td>For non-preventive medical services, plan generally pays…</td>
<td>80% co-insurance, after deductible (you pay 20%)</td>
<td>60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over charges)</td>
<td>80% co-insurance, after deductible (you pay 20%)</td>
</tr>
<tr>
<td>Plan pays 80% co-insurance, after deductible (you pay 20%)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>Plan pays 85% co-insurance, after deductible (you pay 15%)</td>
</tr>
<tr>
<td>Primary Care Physician visits (non-preventive)</td>
<td>Plan pays 80% co-insurance, after deductible (you pay 20%)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
</tr>
<tr>
<td>Features</td>
<td>Sprint Basic Plan</td>
<td>Sprint Health Account Plan</td>
<td>Sprint Consumer Access Plan</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Medical coverage claims administrator</strong></td>
<td>BlueCross BlueShield of Illinois</td>
<td>UnitedHealthcare</td>
<td>BlueCross BlueShield of Illinois</td>
</tr>
<tr>
<td><strong>Per-paycheck premiums</strong></td>
<td>Lowest</td>
<td>Medium</td>
<td>Highest</td>
</tr>
<tr>
<td><strong>Expected out-of-pocket costs</strong></td>
<td>Highest</td>
<td>Medium</td>
<td>Lowest</td>
</tr>
<tr>
<td><strong>Network/Out-of-network</strong></td>
<td>Network</td>
<td>Non-network</td>
<td>Network</td>
</tr>
<tr>
<td><strong>Urgent care and retail clinics</strong></td>
<td>Plan pays 80% co-insurance, after deductible (you pay 20%)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>Plan pays 60% co-insurance, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
</tr>
<tr>
<td><strong>Overland Park, Kan., and Reston, Va., Campus Health Centers</strong></td>
<td>Eligible preventive services covered at 100%</td>
<td>N/A</td>
<td>Eligible preventive services covered at 100%</td>
</tr>
<tr>
<td><strong>High Performance Network (HPN) availability</strong></td>
<td>N/A</td>
<td>Available in many areas</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Specialist care (non-HPN)</strong></td>
<td>Plan pays 80% co-insurance, after deductible (you pay 20%)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>Plan pays 60% co-insurance, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
</tr>
<tr>
<td><strong>Inpatient and outpatient facilities</strong></td>
<td>Plan pays 80% co-insurance, after deductible (you pay 20%)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
</tr>
<tr>
<td><strong>Emergency-room services (true emergencies)</strong></td>
<td>Plan pays 80% co-insurance after your co-pay (once deductible met); you pay 20% co-insurance</td>
<td>Plan pays 80% co-insurance after your co-pay (once deductible met); you pay $125 co-pay and 20% co-insurance</td>
<td>Plan pays 85% co-insurance after your co-pay (once deductible met); you pay $125 co-pay and 15% co-insurance</td>
</tr>
<tr>
<td>Features</td>
<td>Sprint Basic Plan</td>
<td>Sprint Health Account Plan</td>
<td>Sprint Consumer Access Plan</td>
</tr>
<tr>
<td>----------</td>
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<td>----------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td><strong>Medical coverage claims administrator</strong></td>
<td>Blue Cross Blue Shield of Illinois</td>
<td>United Healthcare</td>
<td>Blue Cross Blue Shield of Illinois</td>
</tr>
<tr>
<td><strong>Per-paycheck premiums</strong></td>
<td>Lowest</td>
<td>Medium</td>
<td>Highest</td>
</tr>
<tr>
<td><strong>Expected out-of-pocket costs</strong></td>
<td>Highest</td>
<td>Medium</td>
<td>Lowest</td>
</tr>
<tr>
<td><strong>Network/Out-of-network</strong></td>
<td>Network</td>
<td>Non-network</td>
<td>Network</td>
</tr>
<tr>
<td><strong>Emergency-room services</strong></td>
<td>(non-emergencies – as determined by plan administrator)</td>
<td>Plan pays 60% co-insurance after your co-pay (once deductible met); you pay 40% co-insurance</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40% co-insurance, plus any amounts over allowable charges)</td>
</tr>
<tr>
<td><strong>Bariatric services</strong></td>
<td>(treatment for obesity)</td>
<td>Member must use a bariatric Center of Excellence (if available within 150 miles)</td>
<td>Plan pays 50% co-insurance, after deductible, up to $15,000 lifetime maximum</td>
</tr>
<tr>
<td><strong>Infertility medical treatment</strong></td>
<td>Plan pays 80% co-insurance, after deductible, up to lifetime maximum of $7,500 for medical expenses</td>
<td>For diagnosis office visits ONLY: plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>No other non-network infertility services covered</td>
</tr>
<tr>
<td>Features</td>
<td>Sprint Basic Plan</td>
<td>Sprint Health Account Plan</td>
<td>Sprint Consumer Access Plan</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medical coverage claims administrator</td>
<td>BlueCross BlueShield of Illinois</td>
<td>UnitedHealthcare</td>
<td>BlueCross BlueShield of Illinois</td>
</tr>
<tr>
<td>Per-paycheck premiums</td>
<td>Lowest</td>
<td>Medium</td>
<td>Highest</td>
</tr>
<tr>
<td>Expected out-of-pocket costs</td>
<td>Highest</td>
<td>Medium</td>
<td>Lowest</td>
</tr>
<tr>
<td>Network/Out-of-network</td>
<td>Network</td>
<td>Non-network</td>
<td>Network</td>
</tr>
<tr>
<td>Gender-reassignment surgery</td>
<td>Plan pays 50% co-insurance, after deductible, up to lifetime maximum of $75,000</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specific gender-identity-disorder criteria must be met to receive coverage; see the Sprint Basic Plan Summary Plan Description for more information</td>
<td>Plan pays 50% co-insurance, after deductible, up to lifetime maximum of $75,000</td>
<td>Plan pays 50% co-insurance, after deductible, up to lifetime maximum of $75,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific gender-identity-disorder criteria must be met to receive coverage; see the Sprint Health Account Plan Summary Plan Description for more information</td>
<td></td>
</tr>
<tr>
<td>Claims procedure</td>
<td>No claims to file</td>
<td>You must file claims</td>
<td>No claims to file</td>
</tr>
<tr>
<td>Prescription Drug coverage claims administrator</td>
<td>CVS Caremark</td>
<td>CVS Caremark</td>
<td>CVS Caremark (learn more on the Prescription Drug chart on page 48)</td>
</tr>
<tr>
<td>Specialty pharmacy for specialty medications</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80% co-insurance, after deductible (you pay 20%)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
<td>Plan pays 60% co-insurance of allowable charges, after deductible (you pay 40%, plus any amounts over allowable charges)</td>
</tr>
<tr>
<td>Supply limits, Step Therapy and 90-day fill requirements for certain medications</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>For additional details, including medications not covered, see…</td>
<td>Sprint Basic Plan Summary Plan Description on i-Connect &gt; My Life &amp; Career &gt; Benefits</td>
<td>Sprint Health Account Plan Summary Plan Description on i-Connect &gt; My Life &amp; Career &gt; Benefits</td>
<td>CVS Caremark Summary Plan Description for Sprint Consumer Access Plan on i-Connect &gt; My Life &amp; Career &gt; Benefits</td>
</tr>
</tbody>
</table>
Health Savings Accounts – The rules

A Health Savings Accounts (HSA) is a tax-exempt savings account established exclusively for paying qualified health care expenses. You may open an HSA if you are enrolled in a specifically designated High Deductible Health Plan (HDHP). Beginning in 2013, the Sprint Basic Plan will be considered a HDHP. Sprint’s other Medical/Prescription Drug plans are not considered HDHPs, so employees enrolled in these other plans are not eligible to open an HSA.

If you select the Sprint Basic Plan, you may work with our HSA administrator, ACS|BNY Mellon, to set up your HSA. When you do so and elect to make a payroll contribution of $24 or more per plan year (divided equally among your remaining 2013 paychecks), Sprint will make contributions to your HSA in the amount of $500 (for employee-only coverage) or $1,000 (for family coverage tiers) over the course of the year for each pay period that you have a payroll-deduction contribution; if you join the plan mid-year, these amounts will be prorated accordingly. You can contribute additional pre-tax funds up to an annual total of $3,250 (employee-only coverage) or $6,450 (family coverage tiers); these totals include Sprint’s contribution. If you are age 55 or older in 2013, you are eligible to make an additional catch-up contribution of $1,000. You can use your HSA as you choose to offset your deductible of $1,750 (employee-only coverage) or $3,500 (family coverage levels) or to pay for other eligible out-of-pocket medical, prescription drug, dental and vision expenses.

To receive the Sprint funding, HSAs must be set up with ACS|BNY Mellon; once you’ve enrolled in the Sprint Basic Plan for 2013, you can set up your HSA at https://hsamember.com/HSA/advantagedirect?hpp=002. If you don’t set up your HSA with ACS|BNY Mellon Bank by the 31st day after your Sprint Basic Plan coverage begins, any potential Sprint funding for that period will be forfeited and your HSA payroll deduction contributions withheld during that time will be paid out to you. Once set up, you can use your HSA to pay or be reimbursed for eligible medical, prescription drug, dental and vision expenses as outlined in IRS Publication 502 (http://www.irs.gov/pub/irs-pdf/p502.pdf). You will receive a debit card for use with your HSA and may also request a checkbook. You may also choose to have funds automatically withdrawn from your HSA when you use a BlueCross BlueShield network provider. Note that you may not elect a Health Care Flexible Spending Account if you enroll in the Sprint Basic Plan.

Questions on your HSA can be answered by ACS|BNY Mellon (877-635-5472).

To open and contribute to an HSA, you must meet specific government-regulated eligibility requirements. You:

- Must be enrolled in an HSA-compatible HDHP in 2013, the Sprint Basic Plan will qualify.
- May not have any other medical coverage that is not an HDHP. This means that if you enroll in the Sprint Basic Plan, which is designed to be compatible with an HSA, you will not be able to enroll in a Health Care Flexible Spending Account (FSA) for 2013. Likewise, if your spouse has a Health Care FSA (other than a “limited purpose” FSA) or other non-HDHP through his or her employer that also covers you, you will be ineligible for an HSA through the Sprint Basic Plan. Other types of insurance coverage, such as accident, disability, dental care, vision care, critical-illness or long-term care, are permitted.
- May not be enrolled in Medicare. Once enrolled in Medicare, contributions to the HSA account must stop. The individual can keep any funds in the account prior to enrolling in Medicare and use those funds to pay for qualified medical expenses tax-free. Sprint will not monitor employees’ Medicare status in relation to HSA eligibility; it is your responsibility to comply accordingly.
- May not be claimed as a dependent on another person’s tax return.
- Additional HSA rules can be found at www.hsamember.com.

Important things to remember about HSAs:

- The IRS has specific requirements that a person must satisfy to qualify as an HSA-eligible individual.
- You can use the money that is in your HSA to pay for qualified health care expenses besides just medical and prescription drug (such as dental and vision).
- The HSA account is portable and non-forfeitable, which means it stays with you from year to year and if you change benefit plans, change jobs or if you retire.
- Sprint’s contribution is made in equal payments over the course of the year, while you remain an active employee and continue to make your own per-paycheck HSA contributions.
- You must contribute at least $24 per year to your HSA to be eligible for the Sprint contribution. In addition, to receive a full contribution from Sprint, you must set up your HSA with ACS|BNY Mellon by Jan. 31, 2013; if you begin funding an HSA during the plan year 2013, Sprint’s contributions will begin the month following your enrollment and be prorated accordingly.
- You may waive contributing to an HSA during Annual Enrollment but choose to open one later in 2013; in this case, you would be eligible for a prorated portion of the Sprint funding starting on the first day of the following month.
- The IRS determines the maximum amount that may be contributed to your HSA.
- Expenses incurred by Domestic Partners (and Domestic Partner children) and children who are not your tax dependents cannot be paid for with HSA funds.
- HSAs have an account-maintenance fee, which Sprint will pay while you are enrolled in the Sprint Basic Plan; you may be charged additional fees for optional services, like extra checks or extra debit cards.
Sprint Consumer Access Plan prescription drug charges

Under the Sprint Basic Plan and the Sprint Health Account Plan, prescription drug expenses are generally treated just like medical expenses; once your deductible is met, the plan will begin paying the appropriate co-insurance rate for eligible prescription drug charges, just like medical charges.

The Sprint Consumer Access Plan handles prescription drug charges differently. The below chart outlines your prescription drug deductible, co-pay, co-insurance and other factors to keep in mind when enrolling in this plan. Note that CVS Caremark administers prescription drug coverage for all three of Sprint’s national 2013 Medical/Prescription Drug plans.

### The Sprint Consumer Access Plan - Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Prescription type</th>
<th>You pay (after deductible)</th>
<th>In network</th>
<th>Out of network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible (mail and retail combined)</strong></td>
<td></td>
<td>$100 (employee-only)</td>
<td>$200 (employee-only)</td>
</tr>
<tr>
<td>In- and out-of-network deductibles cross apply. Does not apply to generic or specialty co-pays.</td>
<td></td>
<td>$200 (family tiers)</td>
<td>$400 (family tiers)</td>
</tr>
<tr>
<td><strong>Retail (30-day supply)</strong></td>
<td></td>
<td>Generic drugs</td>
<td>$5 co-pay</td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>20% ($100 max)</td>
<td>30% ($150 max)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand-name drugs</td>
<td>25% ($175 max)</td>
<td>30% ($200 max)</td>
</tr>
<tr>
<td><strong>Retail (90-day supply)</strong></td>
<td></td>
<td>Generic drugs</td>
<td>$15 co-pay</td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>20% ($150 max)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand-name drugs</td>
<td>25% ($200 max)</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Mail order</strong></td>
<td></td>
<td>Generic drugs</td>
<td>$10 co-pay</td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>15% ($150 max)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand-name drugs</td>
<td>20% ($200 max)</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Specialty drugs</strong></td>
<td>Preferred</td>
<td>$100 co-pay per prescription</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Non-preferred</td>
<td>$175 co-pay per prescription</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* A mandatory 90-day fill requirement applies for all managed health conditions. After one 30-day fill and one 30-day refill at a retail pharmacy, members must subsequently obtain 90-day supplies by mail service or through a participating 90-day network retailer.

Choosing Medical/Prescription Drug coverage

When thinking about which Medical/Prescription Drug plan option is right for you, consider:

- What do I think my medical and prescription drug needs will be in 2013? Will my current plan offer me the best coverage for these expected needs?
- How often will my family need to visit the doctor?
- Is my current doctor in one of the networks? If not, do I want to handle claims forms?
- Are the drugs I’m currently taking on the preferred drug list of the plan I’m selecting?
- Which is more important to me – lower per-paycheck premiums or lower deductibles?
- Which type of health-funding account will fit my needs better – a Health Reimbursement Account or a Health Savings Account? Do I meet the federal eligibility requirements for opening a Health Savings Account?
- Am I eligible for the Department of Defense’s TRICARE health benefits program? And if so, do I want to enroll in the TRICARE Supplement Plan through Sprint?
- Do my spouse/domestic partner and/or child(ren) have other coverage options available? How does it compare in cost?

Where to get more information

Still have questions about your Medical plan options? More information is available! You can:

- Review each plan’s Benefit Summary Sheet at i-Connect > My Life & Career > Benefits or sprint.com/benefits
- Visit the website of the companies administering the plans in your area to see their online network directories of doctors and facilities. You can find steps for locating a provider in your area by reviewing the plan’s Summary of Benefit Coverage.
- Check with your doctor or call Member Services for the plan to confirm your doctor’s participation in your local network and acceptance of new patients. Phone numbers for Medical/Prescription Drug claims administrators are available in the Helpful contact information chart beginning on page 104 of this guide.
Did you know that good dental health is important not just for your teeth but for your general overall health? Sprint offers two Dental plan options that pay benefits for a wide range of dental services. You can choose the plan that's right for you based on what you want and need. (You may also waive Dental coverage.)

Sprint offers two Dental options, both administered by Delta Dental:

- Basic Dental plan
- Premium Dental plan

Both options cover exams, cleanings and fillings, as well as comprehensive dental work.

Real savings… use a network provider

Using the services of an in-network dentist is an important way for you to save money. The Sprint Dental options are offered through Delta Dental PPO. This is a separate network from Delta Dental Premier.

If you enroll in Sprint’s Basic Dental plan, you must use a Delta Dental PPO provider for your services to be covered. Services with Delta Dental Premier providers and out-of-network providers are NOT covered by the Basic Dental plan.

Sprint’s Premium Dental plan does not require you to use the Delta Dental PPO network but does provide the highest level of coverage when you use the services of a dentist in this network. Members of the Premium Dental plan have three network options:

- Delta Dental PPO network providers – provide the greatest benefit; providers will file claims directly with Delta Dental and cannot “balance bill” you for charges that exceed the maximum plan allowance
- Delta Dental Premier network providers – though you’ll pay a higher percentage of the costs than with Delta Dental PPO providers, Delta Dental Premier providers will file claims directly with Delta Dental and cannot “balance bill” you for charges that exceed the maximum plan allowance
- Providers outside both the Delta Dental PPO network and the Delta Dental Premier network – you’ll pay a higher percentage of the costs than with Delta Dental PPO. Plus, providers outside of Delta Dental PPO and Delta Dental Premier may not file claims for you and can “balance bill” you for charges that exceed the maximum plan allowance

The Delta Dental PPO network has approximately 165,000 participating dentist access points nationwide. Now is a great time to call your dentist to confirm that he or she is part of the Delta Dental PPO network—just make sure to confirm the full network name, not just “Delta” or “Delta Dental” or “Delta Dental Premier,” but actually “Delta Dental PPO.” You can also log in to deltadental.com to find a network provider and view information related to your eligibility, plan benefits, claims and more.
The details… Dental plans

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Basic Dental Plan</th>
<th>Premium Dental Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per-paycheck premiums**</td>
<td>Delta Dental PPO Network Dentists ONLY*</td>
<td>Delta Dental PPO Network</td>
</tr>
<tr>
<td></td>
<td>Delta Dental Premier*/ Out-of-network</td>
<td></td>
</tr>
<tr>
<td>Employee-only</td>
<td>$1.68</td>
<td>$4.65</td>
</tr>
<tr>
<td>Employee + Spouse/ Domestic Partner</td>
<td>$4.00</td>
<td>$12.13</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$4.05</td>
<td>$12.30</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$6.53</td>
<td>$20.30</td>
</tr>
</tbody>
</table>

* Delta Dental Premier Network is out-of-network.
** Pricing for employees scheduled to work 30 or more hours per week.

Choosing Dental coverage

When thinking about which Dental option to choose, consider:

• Do I visit a dentist for regular cleanings and exams?
• Is my dentist a Delta Dental PPO provider?
• Do I have family members who will require orthodontia services, such as braces?
• Do my spouse/domestic partner and/or child(ren) have other coverage options available? How does it compare in cost?

Diagnostic and Preventive Care (Routine exams, cleanings, X-rays, sealants and fluoride treatments, etc.)

- Plan pays 100% of maximum plan allowance covered, two visits per year (no deductible)

General Dental Care (Fillings, extractions, non-surgical periodontal services and other basic dental procedures)

- Plan pays 50% of maximum plan allowance covered after $25 annual deductible

Major and Restorative Care (Crowns, root canals, surgical periodontal services, bridges, dentures, etc.)

- Plan pays 50% of maximum plan allowance covered after $25 annual deductible
- Newly enrolled participants may only be covered for certain Major and Restorative services after a waiting period

Annual Individual Benefit Maximum

- Diagnostic and preventive care charges do NOT count toward this maximum

Orthodontia (Braces and limited TMJ coverage)

- Not covered
- Plan pays 50% of maximum plan allowance covered after $50 lifetime orthodontia deductible (separate from annual deductible)

Orthodontia Lifetime Benefit Maximum

- N/A
- $1,500 (separate from non-orthodontia maximum)
Vision

Your eye health is important. Regular check-ups can detect chronic conditions and vision-correction needs. We offer a great Vision benefit that pays for eye exams, glasses and contacts and even provides discounts on laser eye surgery, all through the Surency Vision network of eye-care providers featuring EyeMed’s independent private practitioners and retail chains.

Using Vision coverage is simple. Each covered person pays a co-pay for eye exams. Each year, the plan provides an allowance for either glasses or contacts.

You get the most out of the plan when you use professionals within the Surency Vision network, which includes a wide network of covered vision providers, including many national retail chains such as JCPenney Optical, LensCrafters, Pearle Vision, Sears Optical and Target Optical.

Vision coverage levels

When you enroll in Vision coverage, you will be able to sign up for one of three coverage levels depending on which eligible dependents you cover:

• Employee Only
• Employee + One
• Employee + Family (for employees wishing to cover two or more qualifying dependents)

Learn more

Go online and visit surency.com to:

• View information about Surency Vision coverage
• Search for providers online
• Access information on Surency Vision’s Laser Vision Care Program through the U.S. Laser Network and Lasik Plus Centers
• Print a replacement ID card for use when you go to visit your doctor

Choosing Vision coverage

When thinking about Vision coverage, consider:

• What do I anticipate the vision care needs of my family to be?
• Is my current eye doctor in the Surency Vision EyeMed network?
• Do my spouse/domestic partner and/or child(ren) have coverage available through another plan? If so, how does it compare?
## The details… Vision plan

### Benefits with a Surency Vision doctor

<table>
<thead>
<tr>
<th>Per-paycheck premiums*</th>
<th>Employee-only</th>
<th>Employee + One</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1.41</td>
<td>$3.59</td>
<td>$6.82</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eye Exams (one per calendar year)</th>
<th>Plan pays 100% after $15 co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses (once per calendar year) - includes lenticular lenses, scratch-resistant coating, ultraviolet coating, tints and dyes, and (for children under the age of 19) polycarbonate lenses</td>
<td>Plan pays 100% after $25 co-pay*</td>
</tr>
<tr>
<td>Single vision</td>
<td>Plan pays 100% after $50 co-pay*</td>
</tr>
<tr>
<td>Lined bifocals, lined trifocals, and standard progressive</td>
<td>Plan pays 100% after $25 co-pay*</td>
</tr>
<tr>
<td>Frames (one pair per calendar year)</td>
<td>Plan pays 100% of the Surency Vision allowable amount of $135**; you will receive a 20% discount on the charges over the Surency allowable amount; the plan also allows a 20% discount on non-prescription sunglasses and a 40% discount on an additional pair of glasses or prescription sunglasses</td>
</tr>
<tr>
<td>Contacts (once per calendar year)</td>
<td>Plan pays for 100% up to $140 allowance</td>
</tr>
<tr>
<td>Lens fit and follow-up</td>
<td>The maximum you will pay is $55 for standard and you will receive 10% off retail for premium</td>
</tr>
</tbody>
</table>

### In-Network Laser Eye Surgery***

<table>
<thead>
<tr>
<th>LasikPlus Center</th>
<th>Provides greater discounts; the maximum you pay is:</th>
<th>U.S. Laser Network</th>
<th>Discounted rates available; the maximum you pay is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional LASIK with IntraLase (enhancements up to one year)</td>
<td>$695 per eye</td>
<td>PRK</td>
<td>$1,500 per eye</td>
</tr>
<tr>
<td>Traditional LASIK with IntraLase (enhancements for life)</td>
<td>$1,395 per eye</td>
<td>LASIK</td>
<td>$1,800 per eye</td>
</tr>
<tr>
<td>Custom LASIK with IntraLase (enhancements for life)</td>
<td>$1,895 per eye</td>
<td>Custom LASIK</td>
<td>$2,300 per eye</td>
</tr>
</tbody>
</table>

### When using non-Surency Vision providers

<table>
<thead>
<tr>
<th>Eye exam</th>
<th>Surency reimburses you up to $45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td>Surency reimburses you:</td>
</tr>
<tr>
<td>Single Vision</td>
<td>up to $45</td>
</tr>
<tr>
<td>Lined Bifocal and Standard Progressive</td>
<td>up to $65</td>
</tr>
<tr>
<td>Lined Trifocal</td>
<td>up to $85</td>
</tr>
<tr>
<td>Tints and dyes</td>
<td>up to $5</td>
</tr>
<tr>
<td>Frame</td>
<td>up to $47</td>
</tr>
<tr>
<td>Contacts</td>
<td>up to $105</td>
</tr>
</tbody>
</table>

* Pricing for employees scheduled to work 30 or more hours per week.
** There is only one material co-pay when lenses and frames are purchased at the same visit.
*** Call (877) 637-9090 to determine the Surency Vision discount in your area.
Flexible Spending Accounts (FSAs)

What do you do when you know what's going to happen in advance? You plan for it, right? Well, Flexible Spending Accounts (FSAs) are a great way to help you plan for the future. With FSAs, you set aside money — before taxes are deducted — to pay certain health care or dependent day care expenses that you will likely incur. This means lower withholding taxes on your paycheck — and more take-home pay for you!

There are two types of FSAs in which you may enroll:

• **Health Care FSA** — Designed to reimburse for out-of-pocket health care expenses incurred by you or your eligible dependent(s) that are not reimbursable through any other benefits. Examples of eligible expenses are deductibles, co-pays, prescription eyeglasses, vision exams and dental expenses. You can contribute up to $2,500 per year into your Health Care FSA. This limit is set by federal regulations.

• **Dependent Care FSA** — Designed to reimburse for expenses incurred for day care for your eligible dependents. Examples of eligible expenses are day care, after-school care and elder care. You can contribute up to $5,000 per year in your Dependent Care FSA.

Both FSAs are administered by ADP, and you can choose to use one or both of these accounts.

**Important:** As discussed in greater detail on page 46, employees who enroll in the Sprint Basic Plan for 2013 are not eligible to elect a Health Care FSA for 2013. However, Sprint Basic Plan members may contribute to a Sprint-funded Health Savings Account, which can be used to pay for out-of-pocket expenses for many of the same services as a Health Care FSA. Enrolling in the Sprint Basic Plan will not prevent employees from electing a Dependent Care FSA.

**About Flexible Spending Account costs**

You get to choose how much to contribute to your Flexible Spending Account(s), and you get reimbursed for those contributions when you file claims for eligible expenses. Deductions are taken out of your 2013 paychecks in equal increments so that your total annual contribution is the amount you’ve specified (up to each FSA’s maximum annual contribution level — $2,500 per year for health care expenses and $5,000 per year for dependent care expenses). The money you contribute to an FSA is 100% pre-tax, and there are no additional charges to participate in an FSA.

### The details… Flexible Spending Accounts

<table>
<thead>
<tr>
<th>What can be reimbursed?</th>
<th>Health Care Flexible Spending Account</th>
<th>Dependent Care Flexible Spending Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible out-of-pocket health care expenses that are not covered by a medical, prescription drug, dental or vision plan, including deductibles, co-pays and co-insurance. Expenses may be for yourself or any eligible dependent. No reimbursement for over-the-counter drugs and medication without a doctor’s written prescription. If the over-the-counter item is a medicine or drug, you must also submit a customer receipt showing the name of the purchaser (or name of the person for whom the prescription applies), the date and amount of the purchase, and the prescription number.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How much can I contribute?</th>
<th>$100 to $2,500 per year</th>
<th>$100 to $5,000 per year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Can I make changes mid-year?</th>
<th>Changes may be allowed if you have a qualified life event as described on page 15. Otherwise, you may not make changes during the plan year.</th>
<th>Not available for dependent care.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Direct payment of services</th>
<th>You will receive a Health Care FSA debit card from ADP. This card has your account elections “stored” and can be used to pay qualified expenses, eliminating the need for filing a claim for reimbursement in some cases. Substantiation of your expense(s) may be required at any time, so keep all receipts and/or Explanation of Benefit forms.</th>
<th>Not available for dependent care.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How do I reimburse myself using an FSA?</th>
<th>Use your debit card (as described above) and substantiate expenses if required. --OR-- Fax or mail your paper claim form (available at <a href="https://myspendingaccount.adp.com">https://myspendingaccount.adp.com</a>) and supporting documentation to ADP 1866-643-2219 or ADP Benefits Services, P. O. Box 34700, Louisville, KY 40232. --OR-- Complete and submit an online claim form and supporting documentation at <a href="https://myspendingaccount.adp.com">https://myspendingaccount.adp.com</a>. Generally, you will have until March 31, 2014, to submit claims for the 2013 plan year or three months after the end of the month of your termination of employment. Exception: Claims for dependent children who turn age 26 during 2012 must be submitted by Dec. 31, 2013.</th>
<th>Fax or mail your paper claim form (available at <a href="https://myspendingaccount.adp.com">https://myspendingaccount.adp.com</a>) and supporting documentation to ADP. --OR-- Complete and submit an online claim form and supporting documentation at <a href="https://myspendingaccount.adp.com">https://myspendingaccount.adp.com</a>. Generally, you will have until March 31, 2014, to submit claims for the 2013 plan year or three months after the end of the month of your termination of employment.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Claims Administrator</th>
<th>ADP (<a href="https://myspendingaccount.adp.com">https://myspendingaccount.adp.com</a>) Be sure to set up a website account so that you can manage your accounts anywhere, anytime.</th>
<th></th>
</tr>
</thead>
</table>

[https://myspendingaccount.adp.com](https://myspendingaccount.adp.com)

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[https://www.flexdirect.adp.com](https://www.flexdirect.adp.com)
How can bringing home less of my paycheck help me get more for my money?

FSAs allow you to have money taken directly out of your paycheck before taxes. The funds can then be applied to out-of-pocket health care and/or dependent care expenses you experience throughout the year.

Take a look at this tax-saving example. Melanie is a Sprint employee who makes $36,000 a year. About 35% of her annual pay (around $12,000) goes to pay taxes. She anticipates about $1,500 worth of FSA-eligible expenses in 2013. Here’s how Melanie would fare with and without an FSA:

<table>
<thead>
<tr>
<th>Melanie’s earnings, expenses and savings</th>
<th>With FSA</th>
<th>Without FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross annual pay</td>
<td>$36,000</td>
<td>$36,000</td>
</tr>
<tr>
<td>Pre-tax money deposited into her FSA</td>
<td>-$1,500</td>
<td>0</td>
</tr>
<tr>
<td>Remaining taxable income</td>
<td>$34,500</td>
<td>$36,000</td>
</tr>
<tr>
<td>Minus Federal, Medicare and Social Security taxes</td>
<td>-$11,730</td>
<td>-$12,240</td>
</tr>
<tr>
<td>Take-home pay spent on FSA-eligible health care expenses</td>
<td>0</td>
<td>-$1,500</td>
</tr>
<tr>
<td>Remaining take-home pay</td>
<td>$22,770</td>
<td>$22,260</td>
</tr>
<tr>
<td>Annual tax savings</td>
<td>$510</td>
<td>0</td>
</tr>
</tbody>
</table>

By using a Health Care FSA, Melanie brought home an additional $510 for the year!

The rules

There are a few very important rules to know about FSAs:

Each account functions separately. You cannot move money from your Health Care FSA to your Dependent Care FSA (or vice versa). Nor can you use money from one FSA to cover expenses that should actually be claimed from the other account; i.e., you cannot pay a health care expense out of your Dependent Care FSA or a dependent care expense out of your Health Care FSA.

No-carryover rule. Unused money in your account as of the end of the calendar year is lost; you cannot carry that balance forward year to year, and you cannot withdraw the money as cash – so it’s important to plan for your 2013 expenses and contributions carefully! One approach some employees take is to calculate fixed out-of-pocket expenses and add in an additional 20% for unexpected needs.

Claim filing deadline. Generally, claims for eligible expenses for you and your dependents must be filed by the deadline of March 31, 2014 (or three months after the end of the month from your termination of employment, if earlier).

Exception to claims deadline for dependent children turning age 26 during 2013. Expenses may be incurred through the end of 2013 for a dependent child who turns 26 during the calendar year. However, claims for reimbursement for the child MUST be filed by Dec. 31, 2013.

Remember to keep receipts. Documentation of an expense will be required when submitting claims and may be required to substantiate a health care expense charged to the debit card, so keep all itemized receipts.

Health Reimbursement Accounts and your Health Care FSA. You must first exhaust your Health Reimbursement Account (HRA) funds before you can submit claims for covered health services to your Health Care FSA for reimbursement. If you deplete the HRA balance, and receive additional covered health services in a calendar year, then your Health Care FSA may be used and will pay 100% of allowable amounts for any remaining covered health services in that calendar year, up to the allocation in your Health Care FSA. You cannot submit an expense to your Health Care FSA for reimbursement if that expense is paid or reimbursed by an HRA or other plan benefits. For example, if your provider submits a claim for a covered health expense, those amounts will be deducted from your HRA based on your balance at the time of service. You will receive an Explanation of Benefits showing any additional charges not paid by the HRA (e.g., the remainder of your deductible or your co-insurance). At that time you can submit those expenses to your Health Care FSA. You cannot, however, submit the portion of the provider’s charges that were already paid by the HRA. You may use your Health Care FSA for portions of a non-network provider’s charges exceeding the allowable amounts. If your Provider does not submit the claim under this plan (as in the case of some non-network providers), you may submit the claim to the plan or to your Health Care FSA, but not both. If you submit it to the plan and only part of the expenses are covered by your HRA or other plan benefits, at that point you may submit the rest to your Health Care FSA.

Take a look at the details. Decide if funding an FSA is the right choice for your health care and/or dependent care needs. Visit www.myspendingaccount.adp.com for more information and a complete list of health care and dependent day care expenses that qualify for reimbursement through an FSA.

Special rule for highly compensated employees. Federal regulations require both plans to be tested on an annual basis to make sure that highly compensated employees (as defined by regulation) do not contribute more than a permissible amount relative to non-highly compensated employees. If either plan fails this test, the company may need to reduce the contribution elections of highly compensated employees to that plan.

FSA claims for employees leaving Sprint in 2013

If you leave Sprint for any reason during 2013, your final day to incur new expenses eligible for FSA reimbursement and your final day to submit any expenses for reimbursement will now be based on the end of the month of your termination of employment, COBRA continuation or severance – your “benefits end date.” You will be able to incur eligible expenses up until your benefits end date, and you will be able to submit expenses up until the end of the month three months after your benefits end date.
• **Example 1:** Eric’s last day as a Sprint employee is June 15, 2013, and his FSA coverage ends on June 30. Eric will have until June 30 to incur new FSA-eligible expenses and until Sept. 30 to submit for reimbursement any FSA-eligible expenses incurred between Jan. 1 and June 30.

• **Example 2:** Paula’s last day as a Sprint employee is June 15, 2013, but she is receiving salary separation pay through Aug. 15, 2013. Paula’s FSA coverage will continue through Aug. 31, and she will have until that date to incur new FSA-eligible expenses and until Nov. 30 to submit for reimbursement any FSA-eligible expenses incurred between Jan. 1 and Aug. 31.

**Choosing a Flexible Spending Account**

**When thinking about funding a 2013 Health Care FSA, consider:**

• Will I have deductibles, co-pays or co-insurance for medical, prescription drug, dental or vision services?

• What kinds of health expenses will I have that my Medical/Prescription Drug, Dental or Vision plans do not cover?

• Is a member of my family expecting to have any costly medical services, such as surgery or orthodontia treatments?

• Am I enrolling in the Sprint Basic Plan, which will make me ineligible from enrolling in a Health Care FSA (but eligible for a similarly operating Health Savings Account)?

**When thinking about funding a Dependent Care FSA, consider:**

• Do I have children or other family members who meet the guidelines for dependent care reimbursements?

• Do I pay a qualified day-care provider (other than my spouse or other dependent child) to take care of my children inside or outside my home?

• Does my spouse participate in a Dependent Care FSA? (Combined household dependent care election is capped at $5,000.)

**Life Insurance**

With all of our lives so busy, thinking about life insurance may not always be at the top of your to-do list. But when it comes to your personal situation, there are some questions you may wish to consider. Perhaps most important among them: Do you have adequate coverage so that your family has enough money to handle all of the bills in event of a tragedy – from funeral costs to mortgage payments, tuition and retirement? It’s important to have an adequate amount of life insurance to help you ensure financial security for you and those closest to you upon a death. Sprint provides you the opportunity to purchase the level of protection you want for you and your family:

• Employee Life Insurance

• Dependent Life Insurance (for spouses/domestic partners)

• Dependent Life Insurance (for children)

**About Life Insurance premium costs**

Your per-pay-period premiums for Employee Life Insurance are based on your Benefits Eligible Earnings, your age, your smoker/non-smoker status and the amount of coverage you elect. Dependent Life Insurance costs for your spouse/domestic partner are based on age, smoker/non-smoker status and the amount of coverage elected. Deductions for both Employee Life Insurance and Dependent Life Insurance are taken after-tax. Due to the many variables involved, all employees will see different premium costs. Please see the online enrollment system for your specific cost(s).

Life Insurance premium costs for your child(ren) can be found in the Costs section of this guide, which begins on page 22.

**Employee Life Insurance: Coverage for you**

Employee Life Insurance pays a benefit to one or more designated beneficiaries in the event of your death. You choose the coverage amount you need.

Sprint will pay for a total coverage level of either 1x your Benefits Eligible Earnings or $50,000 (whichever is lower). This company-provided coverage is called “Basic Employee Life Insurance.” You may also elect $10,000 of Basic coverage or Waive Coverage. If you elect one of the lower Basic Employee Life levels you will receive a taxable earnings credit for the value difference.

In addition, if you take advantage of the highest level of Basic Employee Life Insurance available to you, you may purchase additional coverage – called Supplemental Employee Life Insurance. This coverage is paid for by you and available in total coverage levels of 1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x your Benefits Eligible Earnings. See the chart on page 64 for more details.

The life insurance carrier may require you to complete proof of good health (called Evidence of Insurability) depending on how much coverage you elect. If so, the life insurance carrier will contact you with further details on how to complete a personal health application.
Employee Life Insurance from Sprint is portable; using the Portability or Life Conversion option, your coverage can be retained no matter where you work. Please see the Summary Plan Description at i-Connect > My Life & Career > Benefits.

Rules for Supplemental Employee Life Insurance
- Evidence of insurability is required if you choose a higher level of Supplemental coverage in excess of $300,000 or coverage that is greater than three times your benefits eligible earnings.
- Maximum Supplemental coverage amount is $2 million.
- If you are an existing employee who has previously waived Life Insurance coverage, you are limited to $10,000 only at this enrollment. Once you have enrolled, you may increase this amount during subsequent enrollments.

Life Insurance beneficiaries
When you enroll in Employee Life Insurance and/or Accidental Death & Dismemberment Insurance (AD&D), you must designate your beneficiaries. You may make changes to these designations at any time during the plan year by going to i-Connect > PeopleSoft Employee Self Service > Benefits Home and clicking on either Basic Employee Life or AD&D within the Benefits Summary section. If you elect Supplemental Employee Life coverage, the Beneficiary designations you make on Basic Employee Life will also be applied to your Supplemental Employee Life Plan election.

The details… Employee Life Insurance

<table>
<thead>
<tr>
<th>Basic Employee Life Insurance (paid for by Sprint)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Waive coverage (receive taxable earnings credit)</td>
<td>$10,000 (receive taxable earnings credit)</td>
</tr>
<tr>
<td>$50,000 or 1x Benefits Eligible Earnings (whichever is lower)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supplemental Employee Life Insurance (premiums paid for by you, and you must first enroll in highest available level of Basic Employee Life Insurance)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Waive coverage 1x Benefits Eligible Earnings</td>
<td>2x Benefits Eligible Earnings</td>
</tr>
<tr>
<td>3x Benefits Eligible Earnings 4x Benefits Eligible Earnings</td>
<td>5x Benefits Eligible Earnings</td>
</tr>
<tr>
<td>6x Benefits Eligible Earnings</td>
<td>7x Benefits Eligible Earnings</td>
</tr>
<tr>
<td>8x Benefits Eligible Earnings</td>
<td></td>
</tr>
</tbody>
</table>

Note: Your “Benefits Eligible Earnings” is defined as your annual base pay plus any targeted incentives or commissions for which you are eligible.

Dependent Life Insurance: Coverage for your family
Dependent Life Insurance provides a benefit to you in the event of the death of your spouse/domestic partner or a child. You pay the cost of this insurance with after-tax dollars.

Rules for Dependent Life Insurance
- Coverage for your spouse/domestic partner is limited to no more than 100% of your Employee Life Insurance amount.
- Coverage for your child(ren) cannot be more than your Employee Life Insurance amount.
- Evidence of insurability is required for spouse/domestic partner coverage over $25,000.
- If Child Life Insurance is selected, any additional children born during the year are covered starting at birth.
- If you are an existing employee who has previously waived Dependent Life Insurance for your spouse/domestic partner, you are limited to only $5,000 coverage. Once you have enrolled, you may increase this amount during subsequent enrollments subject to Evidence of Insurability.

The details… Dependent Life Insurance coverage level options

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>for your spouse/domestic partner</td>
</tr>
<tr>
<td>$5,000</td>
</tr>
<tr>
<td>and/or for your child(ren)</td>
</tr>
<tr>
<td>$5,000 each child</td>
</tr>
</tbody>
</table>

or Waive Coverage

Evidence of Insurability (EOI) and personal health applications
Depending on the Supplemental Employee and/or Dependent Life Insurance coverage level you select, you may be required to show Evidence of Insurability (EOI) by completing a personal health application. If you are signing up for new Supplemental Employee Life Insurance or are increasing your current level of Employee Life Insurance and your new coverage level will (a) exceed $300,000 and/or (b) be more than three times your Benefits Eligible Earnings, you will be required to provide EOI. Any new or increased Dependent Life Insurance for your spouse/domestic partner that exceeds $25,000 requires EOI. Employees and dependents will receive information on how to complete this questionnaire within a few weeks after their 2013 coverage Life Insurance benefit-effective date.
If you elect a Supplemental Employee Life Insurance coverage level that requires EOI, your Employee Life Insurance coverage will remain at the highest multiple-of-pay level not requiring evidence of insurability until the personal health application has been submitted to and approved by the Life Insurance carrier.

If you elect a Dependent Life Insurance coverage level for your spouse/domestic partner that requires EOI, your Dependent Life Insurance coverage will remain at a maximum of $25,000 until the personal health application has been submitted to and approved by the Life Insurance carrier.

EOI is not required for Child Life insurance.

Accidental Death & Dismemberment Insurance

Accidental Death & Dismemberment (AD&D) Insurance gives you added financial protection. It pays full benefits for death and partial benefits for paralysis or loss of limb(s), eyesight, speech or hearing within 365 days of a covered accident. Additional benefits are provided for items like rehabilitation and coma. If you choose family coverage, you will also have access to special provisions for higher education, day care and more. Like Employee Life Insurance, your Accidental Death & Dismemberment Insurance is portable, so you can retain this coverage wherever you go.

You will need to designate beneficiaries for AD&D, and benefit amounts are based on your Benefits Eligible Earnings (as described in the Life Insurance section of this guide on page 64).

About Accidental Death & Dismemberment Insurance

Premium costs

Your pre-tax per-paycheck deductions for Employee AD&D are based on your Benefits Eligible Earnings and the amount of coverage you elect. Due to all of these variables, all employees will see different premium costs. Please see the online enrollment system for your specific cost(s).

Rules for AD&D

- Maximum AD&D benefit is $2 million per employee.
- Coverage for your spouse or domestic partner is equal to 50% of your coverage amount, up a maximum of $750,000.
- Each child is covered at 25% of your coverage amount, up to a maximum of $100,000.
- If there are no covered children at the time of your spouse or domestic partner’s death, the benefit will be 60% of your coverage amount up to a maximum of $900,000.

Basic and Supplemental AD&D

Beginning in 2013, Sprint will re-structure the way it offers AD&D. Now, the benefit will be broken into Basic and Supplemental coverage.

- **Basic AD&D coverage**: Paid for by Sprint. Maximum amount is 1x Benefits Eligible Earnings or $50,000, whichever is lower. Covers employee only.
Supplemental AD&D coverage: Paid for by employee. Must first elect maximum level of Basic AD&D coverage. Available in amounts of 1x, 2x, 3x, 4x, 5x, 6x, 7x and 8x Benefits Eligible Earnings. Can cover employee or employee + family.

You may also elect to receive only $10,000 in AD&D coverage (paid for by Sprint) or waive AD&D coverage entirely.

Deciding on Life Insurance and Accidental Death & Dismemberment Insurance

When thinking about Life and Accidental Death & Dismemberment Insurance (AD&D, covered in more detail in the next section), consider:

- Do I have other life insurance?
- Do I have children or other dependents who depend on my income?
- Does my spouse/domestic partner have life insurance?
- Would my surviving spouse/domestic partner or children be able to enjoy the same lifestyle we have today if I die?
- What other sources of income are available to my beneficiaries?
- Are my children covered by any other life insurance policies?
- In case of an accident causing major injury or death, do I have other forms of insurance?

The details… Accidental Death & Dismemberment Insurance

<table>
<thead>
<tr>
<th>AD&amp;D Coverage</th>
<th>Basic AD&amp;D (paid for by Sprint)</th>
<th>Supplemental AD&amp;D (premiums paid for by you, and you must first enroll in highest available level of Basic AD&amp;D)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Waive coverage (receive taxable earnings credit)</td>
<td>Waive coverage (receive taxable earnings credit)</td>
</tr>
<tr>
<td></td>
<td>$10,000 (receive taxable earnings credit)</td>
<td>1x Benefits Eligible Earnings</td>
</tr>
<tr>
<td></td>
<td>$50,000 or 1x Benefits Eligible Earnings (whichever is lower)</td>
<td>2x Benefits Eligible Earnings</td>
</tr>
<tr>
<td></td>
<td>3x Benefits Eligible Earnings</td>
<td>4x Benefits Eligible Earnings</td>
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<td></td>
<td>4x Benefits Eligible Earnings</td>
<td>5x Benefits Eligible Earnings</td>
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<tr>
<td></td>
<td>6x Benefits Eligible Earnings</td>
<td>7x Benefits Eligible Earnings</td>
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<tr>
<td></td>
<td>7x Benefits Eligible Earnings</td>
<td>8x Benefits Eligible Earnings</td>
</tr>
</tbody>
</table>

Note: Your “Benefits Eligible Earnings” is defined as your annual base pay plus any targeted incentives or commissions for which you are eligible.

Already enrolled in Sprint AD&D coverage for 2013?

Because of the way AD&D coverage is being re-structured in 2013, if you are enrolled in this benefit through Sprint for 2013, it is strongly recommended that you actively make an election for your desired coverage level for 2013. If you are currently enrolled in 2013 AD&D coverage of 1x Benefits Eligible Earnings (BEE) or higher and you do not actively enroll in a different level (or waive coverage) for 2013, you will be automatically enrolled in Supplemental coverage at the same level of coverage plus the highest level of Basic coverage for which you are eligible. This will effectively raise the total coverage in 2013.

Example 1: For 2013, Joe is enrolled in employee-only AD&D coverage in the amount of 4x his BEE. If he does not make a different election during Annual Enrollment, his 2013 AD&D coverage will be Basic employee-only coverage of 1x BEE ($50,000 maximum) plus Supplemental employee-only coverage of 4x BEE.

Example 2: For 2013, Regina is enrolled in employee + family AD&D coverage in the amount of 2x her BEE. If she does not make a different election during Annual Enrollment, her 2013 AD&D coverage will be Basic employee-only coverage of 1x BEE ($50,000 maximum) plus Supplemental employee + family coverage of 2x BEE.
Disability

Prolonged illness and disabling injuries can happen without warning. While we may never be able to fully plan for these events, it’s good to know that we can take steps to minimize our losses during such unfortunate circumstances. Disability benefits pay you money for an approved disability when you are unable to work for a period of time because of an illness or injury. Sprint provides company-paid disability coverage for employees who have worked for the company a year or more.

Sprint offers two Disability programs:
- Short-Term Disability (STD) – 75% coverage provided by the company
- Long-Term Disability (LTD) – 50% coverage provided by the company; additional coverage can be purchased by employee

If you are eligible, STD and LTD benefits are provided so that you receive some replacement income during times you are unable to work due to a disabling medical condition. If you exhaust your STD benefit and continue to be unable to work due to a documented medical condition, you may then be eligible for LTD benefits (if approved by Sprint’s LTD administrator). Both STD and LTD pay benefits based on your earnings. However, STD and LTD define the term “earnings” differently. For LTD, “earnings” refers to your annual base pay plus targeted sales commissions and/or targeted Short-Term Incentive compensation. For STD, “earnings” refers to your usual rate of pay, including targeted sales incentive or commission where applicable, as of your last day worked prior to disability, excluding special pay such as overtime pay or shift differential and any fringe benefits, extra compensation or bonus.

About Disability costs

Once you have been employed by Sprint for 12 or more months, Short-Term Disability coverage for 75% of earnings is provided by the company at no cost to you. This coverage lasts for a maximum benefit period based on your number of completed years of service. In addition, Sprint has partnered with Unum to offer employees the opportunity to purchase separate individual short-term-disability coverage (effective first of the month following 60 days of employment) at a discounted rate. See the Bigger Picture > Voluntary Benefits section of this guide, beginning on page 77, for more details about the Unum offering.

Long-Term Disability coverage for 50% of earnings is provided by Sprint. Employees may purchase a higher level of Long-Term Disability coverage pre-tax. Your per-paycheck premiums for this additional coverage, which are based on Benefits Eligible Earnings, your age and amount of coverage elected, can be found in the online enrollment system in Employee Self Service.

The details… Disability coverage options

<table>
<thead>
<tr>
<th></th>
<th>Short-Term Disability</th>
<th>Long-Term Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage level</td>
<td>Replaces 75% of base pay plus annualized sales commission (when applicable)</td>
<td>Replaces 50%, 55%, 60% or 65% of Benefits Eligible Earnings</td>
</tr>
<tr>
<td>Amount provided by Sprint</td>
<td>75% (maximum level)</td>
<td>50% up to $12,000 monthly maximum; employees may purchase additional coverage levels up to a monthly maximum of $25,000 (including company-paid coverage)</td>
</tr>
<tr>
<td>Benefits start date</td>
<td>Benefits begin on the eighth day of Disability</td>
<td>Benefits are payable after 180-day disability waiting period</td>
</tr>
<tr>
<td>Maximum Benefit Period</td>
<td>Benefits payable up to 26 weeks based on completed years of service (see chart on page 72)</td>
<td>Based on age (see chart on page 73)</td>
</tr>
</tbody>
</table>

Important: If you work in California, Hawaii, New Jersey, New York or Rhode Island, state-mandated disability benefits may apply and could vary from those described here.
STD Maximum Benefit Period

Your company-provided STD benefit is based on your completed years of service. After one year of continuous service and 1,250 productive hours worked within the last 12 months, employees will be eligible for a STD maximum benefit period of six weeks. Employees will be eligible for an additional two weeks of STD benefits for every additional completed whole year of service as of the date of their disability, as shown on this chart:

<table>
<thead>
<tr>
<th>Completed years of service</th>
<th>Maximum Benefit Period (in weeks)</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<td>9</td>
<td>22</td>
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<tr>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>11+</td>
<td>26</td>
</tr>
</tbody>
</table>

Choosing Disability coverage

Short-Term Disability coverage is automatically provided to eligible employees at a 75% coverage level after 12 months of employment. Employees can choose additional (but separate) coverage through our vendor Unum as described in the Bigger Picture section on page 77.

Long-Term Disability coverage is provided to eligible employees at a 50% coverage level, but employees may purchase a higher coverage level through Sprint. When thinking about Long-Term Disability coverage, consider:

• If something happens that keeps me from working for a long time, does my family have other financial resources?
• What level of Long-Term Disability coverage is sufficient to provide for my own or my family’s needs?

LTD Maximum Benefit Period

Your maximum LTD benefit duration is based on your age (as of the date your disability leave begins) as shown on this chart:

<table>
<thead>
<tr>
<th>Long-Term Disability Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your age on date disability leave begins</td>
</tr>
<tr>
<td>61 and under</td>
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<tr>
<td>62</td>
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<tr>
<td>63</td>
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<td>64</td>
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<td>66</td>
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<tr>
<td>67</td>
</tr>
<tr>
<td>68</td>
</tr>
<tr>
<td>69 and over</td>
</tr>
</tbody>
</table>
Group Legal Plan
Whether you’re buying a new home, drawing up a will or just in need of legal advice, the Group Legal Plan from Hyatt Legal can give you easy access to experienced attorneys. Plus, you’ll receive a wide range of covered legal services at an affordable price and an attorney is just a phone call away.
The Group Legal Plan includes
• Adoption, guardianship and conservatorship (contested and uncontested)
• Assistance with purchase, sale or refinancing of primary, second or vacation home
• Boundary or title disputes
• Civil litigation defense
• Deed preparation and immigration assistance
• Debt collection and identity-theft defense
• Home-equity loans for primary, second or vacation home
• Property tax assessment
• Protection from domestic violence
• Security-deposit assistance (primary residence – tenant only)
• Wills and estate planning
• Zoning applications

When you use a participating plan attorney for covered services, there are no deductibles, co-pays waiting periods or claim forms. You also have unlimited telephone and office consultations.

Group Legal Plan cost
The after-tax cost of the Group Legal Plan is $8.45 per pay period.

The bigger picture
Sprint also offers many other great programs that you and your family can take advantage of year-round. Read on to learn more!

Note: For most Sprint programs, you must work at least 20 hours a week. Some programs, such as Paid Time Off, adjust accruals based on other factors like employee classification, full/part-time status and years of service.

Discount programs
Sprint Employee Discount Site
The Sprint Employee Discount Program is a fast, convenient website that provides access to exclusive discounts on merchandise and services from top brand-name retailers, online stores and local merchants. Products range from clothing to computers, gifts to golf and tickets to toys. This is a benefit that employees can use every day of the year.

Learn more: i-Connect > My Life & Career > Benefits

Employee Phone Programs
We are proud of our products and services, and one way we show it is through our employee phone discount program. Through our three Employee Phone Programs you get a zero-dollar rate plan for yourself and discounted rate plans for your family, friends and other referrals. Here’s what’s available.

For you: Employee Wireless Discounts
Employee Wireless Discounts offers both choice and flexibility. Free wireless services are offered that include unlimited voice, unlimited messaging, unlimited Web, unlimited turn-by-turn navigation and Sprint TV. Other program benefits include flat-rate pricing for devices (never a mail-in rebate) and 25% off accessories and services like Total Equipment Protection and Family Locator. Heavily discounted services are available for one active mobile broadband device (air cards/mobile hotspots), one embedded device (tablets, netbooks and notebooks) and one Sprint Phone Connect line.

For your friends and family: Sprint Wireless Advantage Club
The Sprint Wireless Advantage Club offers wireless discounts for family members and close friends. You can choose between several rate plans starting at $20/500-minute plan for basic phones and $30/500-minute for smartphones. Other program benefits include 25% off accessories, discounted services for 3G/4G mobile broadband and embedded devices (tablets, netbooks and notebooks). Employees accept liability for all Advantage Club subscribers. You may sponsor up to 30 lines of service under Advantage Club.

Note: Migrations of consumer Sprint accounts to Advantage Club are permitted in certain circumstances. Please see i-Connect > My Life & Career > Benefits for details.

For referrals: Everything Plus Referral Program
The Sprint Everything Plus Referral Program provides an exciting way for employees to refer new customers to Sprint. A variety of individual and family plans offer generous service discounts – more minutes for a lower monthly charge than the equivalent consumer plans. And the Everything Plus Data rate plans now include Any Mobile, AnytimeSM making these rate plans an even better value. Unlike Employee Wireless Discounts and the Advantage Club, you are not financially liable for your referrals’ accounts.

Learn more about these discount programs: i-Connect > My Life & Career > Benefits
Retirement and Wealth

Your physical health is important, but so is your financial health. That’s why Sprint offers a selection of benefits designed to help you invest for the future.

**Sprint Nextel 401(k) Plan**

Build your financial security for the future while reducing your current taxable income through the Sprint Nextel 401(k) Plan.

- You can make pre-tax, Roth or after-tax contributions to the 401(k) Plan up to 80% of your eligible pay (subject to certain regulatory limits).
- You choose 401(k) plan investment options for your contributions. Company-matching contributions are invested in the same investment options you have chosen for your own contributions. You can easily monitor the growth toward your financial goals.
- Your contributions are immediately 100% vested.

Learn more and enroll: [i-Connect > My Life & Career > Benefits](https://netbenefits.com/sprint) or call **(800) 877-4015**

**Employees Stock Purchase Plan (ESPP)**

The ESPP provides the opportunity for you to purchase Sprint Nextel common stock at a 5% discount. Contribute from 1%-20% of your annual compensation (base pay plus any commissions) to your ESPP account.

- Your ESPP account increases each pay period through convenient payroll deductions.
- Stock is purchased at the end of each quarter at a 5% discount.

- You can purchase up to a value of $25,000 worth of Sprint stock each calendar year.

Learn more: [i-Connect > My Life & Career > Benefits](https://netbenefits.com/sprint) or call **(800) 877-4015**

**Financial planning and workplace education**

Sprint works with Ameriprise Financial Services to provide you the tools and resources to help you make sound financial decisions.

- Complimentary initial one-on-one consultation with a financial adviser
- Online financial-planning tools
- Workplace seminars
- Discounts on financial-advisory services

Learn more: [ameriprise.com/sprint](https://ameriprise.com/sprint) or call **(800) 437-3500**

**Retiree Health Care Benefits**

Sprint currently provides retirees and their families with access to Medical/Prescription Drug and Dental plans similar to those available to employees.

**Sprint Retirement Pension Plan**

If you were employed by Sprint prior to Aug. 12, 2005, you may be eligible for a benefit under the Sprint Retirement Pension Plan. To determine eligibility and run pension or retiree health care estimates, visit [https://sprintretirementservices.ehr.com](https://sprintretirementservices.ehr.com) or call **(866) 333-7311**.

Sprint’s Voluntary Benefits offerings complement our robust benefits package with key programs in which employees can enroll as needed. New hires may apply for coverage in all of the Voluntary Benefits programs during their first 31 days of employment. Guaranteed coverage is available for some plans, but others may require employees to complete a medical questionnaire.

**Individual Short-Term Disability Insurance**

In addition to the 75% Short-Term Disability coverage provided for eligible employees by Sprint (described on page 72), you can help protect your finances with Unum’s Individual Short-Term Disability benefit. This benefit can help replace a portion of your salary should you experience a qualified disability. The plan pays monthly benefits in the event of sickness and non-work-related incidents. Medical-history questionnaire required if enrolling after your first 31 days of employment.

Employees are eligible upon employment (rather than after one year of service for company-provided STD coverage). Employees may apply for coverage of up to 60% of gross monthly salary (base pay without bonus or commissions) to a maximum of $5,000.

Learn more or enroll: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call **(888) 693-1388 (option 6)**.

**Universal Life Insurance**

No matter who is important to you, life insurance can make a difference, both now and in the future. Whether it’s protecting your family’s finances, building a fund for retirement or borrowing money, having enough life insurance shows that you care. Think about Universal Life Insurance while planning for your future and theirs. It offers lifelong protection that can stay with you no matter where you live or work.

Universal Life Insurance is available to Sprint employees through Allstate Benefits/AHL Universal Life Insurance. Guaranteed coverage not available; all applications are underwritten and issued on a simplified issue basis.

Learn more: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call **(888) 693-1388 (option 4)**.

**Critical Illness Insurance**

Designed as a complement to your current health coverage, MetLife Critical Illness Insurance pays separate lump-sum benefit payments if you or your covered dependent experiences qualifying medical conditions in three distinct areas – cancer-related conditions, heart-related conditions, and other conditions and meet the group policy and certificate requirements. You can use the benefit payment as you see fit to help pay for additional medical expenses or day-to-day living expenses.

Please review the Outline of Coverage/Disclosure Document for specific information about Cancer benefits. If you do not enroll during your initial 31-day enrollment period, you may not enroll until the next opportunity is specified as determined by Sprint.

Learn more or enroll: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call **(888) 693-1388 (option 4)**.

**Voluntary benefits**

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Employees are eligible upon employment (rather than after one year of service for company-provided STD coverage). Employees may apply for coverage of up to 60% of gross monthly salary (base pay without bonus or commissions) to a maximum of $5,000.

Learn more or enroll: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call **(888) 693-1388 (option 6)**.

**Universal Life Insurance**

No matter who is important to you, life insurance can make a difference, both now and in the future. Whether it’s protecting your family’s finances, building a fund for retirement or borrowing money, having enough life insurance shows that you care. Think about Universal Life Insurance while planning for your future and theirs. It offers lifelong protection that can stay with you no matter where you live or work.

Universal Life Insurance is available to Sprint employees through Allstate Benefits/AHL Universal Life Insurance. Guaranteed coverage not available; all applications are underwritten and issued on a simplified issue basis.

Learn more: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call **(888) 693-1388 (option 4)**.
Long-Term Care Insurance

Have you ever thought what you would do if you couldn’t bathe or dress yourself? If you needed help getting from place to place, who would be there to help you and how would you pay for it? The need for assistance may result from an illness, accident or advancing age. Unum’s Long-Term Care Insurance can help pay for the needed care. It can help by paying a benefit, once you qualify, which may be used any way you wish. The insurance is flexible and can be tailored to fit specific needs. Enrollment requires completion of a paper application and an Evidence of Insurability Form (medical questionnaire) if enrolling after 31-day enrollment period.

Learn more: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call (888) 693-1388 (option 2).

Auto and Home Insurance

Feel secure knowing that you have the choice between three best-in-class carriers: MetLife Auto & Home, Liberty Mutual and Travelers. These trusted leaders in the insurance industry can help you protect your most important assets. You have access to special savings on the coverage you need. What’s more, you can easily budget your premium payments through automatic payroll deduction. Request quotes from all three to find the coverage that is best for you.

Coverage, rates and discounts are available in most states to those who qualify.

Learn more: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call (888) 693-1388 (option 1).

Veterinary Pet Insurance

Pets are unpredictable. While it is hard to anticipate accidents and illnesses, VPI Pet Insurance makes it a little easier to be prepared for them. From preventive-care visits to significant medical incidents, VPI helps provide protection for pets when they need it most. VPI policies cover a multitude of medical problems and conditions related to accidents and illnesses, including cancer. Coverage is available for dogs, cats, birds and exotic pets. Best of all, policyholders are free to use any veterinarian worldwide.

Learn more: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call (888) 693-1388 (option 3).

Group Accident Insurance

Group Accident Insurance from Aflac pays a benefit for injuries sustained as the result of a covered accident. When such incidents happen, having quick access to additional funds can be invaluable. With Group Accident Insurance, there is no limit to the number of claims, you can get guaranteed issue (no underwriting required), and you’ll receive convenient payroll deduction of your premiums. The coverage acts as a complement to your existing forms of coverage, such as Medical/Prescription Drug coverage, providing you safety and security in case of unforeseen events. Additionally, the coverage is portable; should you leave Sprint, you can take your Aflac Group Accident Insurance with you. Guaranteed enrollment is available anytime you enroll.

Learn more: [https://sprintbenefithub.com](https://sprintbenefithub.com) or call (888) 693-1388 (option 8).

Additional valuable programs

Sprint cares about the health and well-being of you and your family. That’s why we provide a full array of programs and services designed to help you out in life. Be sure to check out these additional valuable programs.

Get rewarded for getting healthier with Sprint Alive!

Did you know that you can get financially rewarded for improving or maintaining your health? It’s true – Sprint Alive! offers several great (and free) telephonic or online Health Improvement Programs for employees and dependents. Programs include those focused on nutrition, maternity, diabetes lifestyle, exercise, smoking cessation, stress management and weight loss. You may be eligible for up to $100 in cash-equivalent prizes. Call your Sprint Alive! Health Advocate at 866-90-ALIVE (25483), dial *545 from your Sprint phone or visit sprintalive.com for more information.

Sprint Alive!

Sprint’s employee wellness program, Sprint Alive!, is your partner for a healthier life. Sprint Alive! is a resource that gives you and your family quick and easy access to condition assistance and health improvement programs that can make a difference in your life. In addition, you can call Sprint Alive! toll-free 24 hours a day to connect with an experienced registered nurse who can assist you with both short-term acute and long-term complex health needs – all at no cost. Through Sprint Alive!, all employees and covered spouses/domestic partners can participate in a Health Assessment at any time during the year. The proactive, preventive information it delivers can help you manage even minor health issues before they get out of control. It’s a simple way to look at your life and health habits. It helps you identify areas to improve and things to watch out for, plus confirms what you may be doing right. Plus, employees who take their Health Assessment during a specific time window may be eligible for the Sprint Health Living Discount on their Medical/Prescription Drug premiums; see the Discounts for a healthier life section on page 8 for more details.

Sprint Alive! is completely confidential. All Sprint Alive! nurses and Health Advocates are employed by outside companies with which Sprint has contracted to provide this health and wellness service. No one at Sprint or employed by Sprint will ever see or have access to any of your personal health care information.
With Sprint Alive!, you can:
• Work with your own personal Health Advocate
  • Participate in the pre-natal program designed with the health of you and your baby in mind. You will receive pregnancy-wellness information as well as materials specific to your needs and more.
• Sign up for the Sprint Alive! QuitPower tobacco-cessation program to receive ongoing support and eight weeks of Nicotine Replacement Therapy.
• Participate in coaching sessions on wellness programs like stress management, heart health, diabetes, nutrition, weight and exercise.
• Learn more about key health conditions such as diabetes, asthma, kidney disease, cancer, heart failure and coronary artery disease.
• Check out the capabilities using weight and exercise trackers, nutrition logs, and other health-management tools (such as tobacco cessation) available to you in your own online Personal Health Center.

Learn more: sprintalive.com or call (866) 90-ALIVE (25483) or dial *545 on your Sprint phone

GuidanceResources – Sprint’s employee assistance program

The stress of managing daily life (whether big or small) can affect your work, health and family. That’s why 24 hours a day, seven days a week you gain control over your busy life and move forward on the things you want to do. GuidanceResources is Sprint’s employee assistance program with a host of free services for you and your family. One call is all it takes to access:

• Confidential consultation on personal issues – Experienced clinicians counsel on topics such as relationships, job pressures, problems at home, grief, stress, anxiety and depression.
• Personal convenience and work/life needs – Receive a personalized reference package with helpful resources and literature for finding child/elder care, pet care, college planning, home repair, vacation planning, relocation needs and other issues that impact your everyday life.
• Legal information and resources – Attorneys available for free, confidential 30-minute consultations or for assistance (with discounted fees) for legal matters including family law, debt obligations, real estate transactions and civil lawsuits. If you need a lawyer to represent you in person, you can get a referral to a local attorney for a free 30-minute consultation and services at a 25 percent discount.
• Identity Theft – If you are the victim of identity theft, the legal, financial, emotional and work/life challenges can be overwhelming, and take up a huge amount of your time to resolve. A team of experts can help you with every aspect of identity theft, from the legal and financial issues to work/life assistance to counseling to address the emotional issues and stress that identity theft can cause.
• Financial Information – Money is on everyone’s mind these days. Staying on a budget, getting out of debt, dealing with credit cards, saving for long-term goals, taxes … these are just some of the many financial issues GuidanceResources can help with. Talk to a licensed CPA, CFP or other financial professional.
• Online information, tools and services – Resources include online counselors, helpful answers and interactive tools.

Learn more: guidanceresources.com (company ID: SPRINT) or call (888) 303-3957

Adoption Assistance Program
If you are adopting a child, Sprint provides up to $5,000 per child to assist with expenses with a maximum of two children per year.
Learn More: i-Connect > My Life & Career

Rewards and Recognition programs
Recognition is a powerful way to motivate our employees, build our culture and drive success. At Sprint, we take the opportunity to let employees know we appreciate them and have robust programs to support our passion for and commitment to recognition. So, no matter where you work in Sprint, there are managers and co-workers who are just waiting to recognize you.

Learn more: sprint.com/recognize

Educational Assistance Program
Sprint believes it is important to invest in the educational future of our employees. This program encourages eligible employees to continue outside educational courses to help improve professional skills. Sprint reimburses up to $2,625 per year for eligible, qualifying undergraduate- and graduate-course expenses. In addition, employees have the opportunity to work one-on-one with experienced education advisors who provide counseling on employees’ best ways to cost- and time-effectively reach their academic goals. Additional services include discounted rates to many popular colleges and universities across the country.

Learn more: i-Connect > My Life & Career

Matching Gift Program
The Sprint Foundation will match employee charitable contributions from $25 to $5,000 annually to approved educational institutions, arts and cultural organizations, public-broadcasting stations, environmental organizations and select youth-development organizations. Gifts to the American Red Cross for disaster relief in the United States are also eligible for a matching gift. Please refer to the Matching Gifts guidelines on i-Connect for a complete list of program eligibility requirements.

Learn more: Go to i-Connect and type “matching” in your Web browser

The Sprint Volunteer Program
The Sprint Volunteer Program opens doors for our employees to actively volunteer in their local communities through company-sponsored projects, group-volunteer opportunities organized by employee community volunteer committees and a dedicated volunteer website, which provides information and resources for volunteering.
Through the Dollars for Doers program, employees who volunteer at least 40 hours during a calendar year to a qualified non-profit organization can receive a $250 Sprint Foundation grant for that organization.

Learn more: sprint.com/volunteer

**Business Travel Accident (BTA) Insurance**

Business travel may be a part of your job with Sprint. Or, you may be transferred and relocated to another Sprint work location. If so, we want you and your family to be financially protected when traveling for business. The Sprint Business Travel Accident (BTA) Plan provides just that type of insurance protection. BTA pays benefits in the case of a sudden and unforeseen accident that causes loss of life or limb or results in permanent paralysis when traveling for company business or during the relocation process. Sprint's BTA coverage is insured by The Hartford, and enrollment is automatic.

**Travel Assistance**

We recognize that with transportation becoming more efficient and effective, more employees are traveling across the globe for business as well as pleasure. Many times, travelers face unique challenges and unpredictable circumstances. By providing a travel-assistance service, we will be able to offer you a familiar standard of care in an unfamiliar place, whether it's medical, legal, informational or personal assistance you require. So if you become seriously ill, need a prescription filled, require a legal referral or lose your travel tickets when traveling 100 miles or more from your home, the program can assist you. The Travel Assistance program is provided free-of-charge to employees and families on business travel on a 24-hour basis. For travel assistance coverage for personal travel, you must be enrolled in Sprint's Accidental Death and Dismemberment coverage.

**Medical Benefits Abroad**

When global business travel or employment takes you far from home, you need the security of knowing you have adequate medical coverage no matter where you are. The CIGNA International Medical Benefits Abroad (MBA) program gives peace of mind to full-time employees on global business travel, when the time outside of their country of citizenship is for less than 181 days. MBA coverage begins when you leave and ends when you return. It offers services to make international business travel and short-term international assignments easier.

Learn more: For BTA Insurance, Travel Assistance and Medical Benefits Abroad, go to i-Connect > My Life & Career

**Time away from Sprint**

Sprint provides a variety of ways to give you the time you need away from work. Additional information about leave programs can be found at Sprint > My Life & Career.

**Paid Time Off (PTO)**

If eligible, you start to accrue PTO on your 31st day of employment. Accrual rates are based on employee classification, full/part-time status and years of service – higher accruals come with more service. Please refer to the Employee Guide on i-Connect for details on employee classification and a link to the PTO policy.

**Donating Paid Time Off Hours**

If you know of an employee who is in need of PTO to care for themselves or a family member due to a serious medical situation and the employee has exhausted his or her PTO balance and is not eligible for any other paid time off benefits (and hasn't yet exhausted other paid time off benefits), you may voluntarily donate some of your accrued hours. Employees may also donate PTO for use by employees who are in a president-declared disaster area and make a request for it.

**Holidays**

Sprint employees enjoy eight holidays per year. You may have eight set holidays, or if you're in a retail store or designated contact center, you'll have a mix of set days and floating holidays, so that we can continue to serve our customers year-round.

**Military Duty**

Sprint supports employees who must take time away from work to participate in military training duty and extended active duty assignments. If you are in the Reserves or National Guard you will receive the difference between your base pay and your military base pay up to a maximum of two work weeks each calendar year for training. Compensation during involuntary call-ups due to national emergencies, presidential declarations of military action and other cases will be handled separately.

**Bereavement**

Sprint strives to provide our employees reasonable time off when they must manage the difficulties associated with the death of a family, blended family or household member. If you suffer a loss, you may be eligible for up to:

- Ten days paid bereavement leave for the loss of a spouse, domestic partner or your child ("child" includes natural, legally adopted, foster, step or of a domestic partner).
- Five days of paid bereavement leave for the loss of your parent.
- Three days of paid bereavement leave for the loss of your spouse's or domestic partner's parents; and the loss of your siblings, grandparents, grandchildren, aunt or uncle.

There is no bereavement benefit to you for the loss of your spouse's or domestic partner's siblings, grandparents, grandchildren, aunt or uncle.
We ask that you notify your manager before taking bereavement time off. Some departmental guidelines may require a funeral program or newspaper obituary upon request. If you have questions about the bereavement benefit or the use of Paid Time Off in other bereavement situations, be sure to discuss those with your manager.

**Disaster Leave**

Natural disasters such as hurricanes, floods and tornadoes can affect employees and our ability to do business. When disasters strike, you may be allowed to take emergency disaster leave up to two days with pay to attend to your home or personal belongings. If more than two days are needed, you must take time off without pay or use PTO. Any leave must be approved by your manager.

**Other Types of Leave**

- **Unpaid Personal Leave of Absence** – Once in a while, you may need to take extended time away from work to manage personal obligations. When paid time off isn’t enough, you may apply for an unpaid personal leave of absence. The minimum time granted for an unpaid personal leave of absence is 30 days.
- **Family/Medical Leave** – Sprint endorses the federal Family Medical Leave Act (FMLA) and complies with its requirements and definitions.
- **Domestic Partner Leave** – Available to care for a certified domestic partners’ serious health condition.

**Workers’ Compensation**

To protect your rights under Workers’ Compensation laws following any accident or injury suffered on the job you need to report the incident to your manager or supervisor within 24 hours. Workers’ Compensation laws vary from state to state. For more information, contact Risk Management at (800) 777-6892.

**Important information**

**Proof of dependent status**

Sprint, insurance companies, and other claims administrators reserve the right to verify the eligibility of your covered dependents. You might be asked to provide proof of dependent status by providing a marriage certificate, domestic partnership certification, birth certificate, tax return, etc. See full details in the Enrollment & Eligibility section of your plan’s Summary Plan Description at i-Connect > My Life & Career > Benefits.

**Conversion of Life Insurance**

Conversion or portability of life insurance is available upon separation from Sprint. Please refer to the Summary Plan Description at i-Connect > My Life & Career > Benefits.

**Qualified medical child support orders**

Medical coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions and procedures as all other plan participants.

**Women’s Health and Cancer Rights Act of 1998**

As required by the Department of Labor and the Department of Health and Human Services, Sprint is providing this notice about the Women’s Health and Cancer Rights Act of 1998. This notice serves as the annual notice required by the Department of Labor.

The Women’s Health and Cancer Rights Act of 1998 provides certain benefits for mastectomy-related services. These benefits include coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications for all stages of the mastectomy, including lymphedema.

**Children’s Health Insurance Program (CHIP)**

If you are eligible for health coverage from Sprint, but are unable to afford the premiums, some states have premium-assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. Additional details can be found on i-Connect.

**Newborns’ and Mothers’ Health Protection Act**

As required by the Department of Labor, Sprint is providing this notice about the Newborns’ and Mothers’ Health Protection Act. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).
General Notice of COBRA Continuation Coverage Rights

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under any Sprint Group Health Care Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The right to COBRA continuation of group health care coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group healthcare coverage, including medical/prescription drug, dental, vision and health care flexible spending account coverage, under terms of the applicable plan (“Plan”). It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s summary plan descriptions or contact the Plan Administrator, as described in this notice. The summary plan descriptions are available on i-Connect.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of an event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any one of the following qualifying events happens:

- Your hours of employment are reduced; or
- You are absent from work by reason of approved military service leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
- Your employment ends for any reason, other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any one of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason, other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason, other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "dependent child."

A child born to, adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a qualified beneficiary provided that the covered employee is a qualified beneficiary and the covered employee has elected continuation coverage for himself or herself.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 calendar days after the qualifying event or the loss of coverage, whichever is later. You must notify the Plan Administrator using the notice procedures specified below. If these notice procedures are not followed, any spouse or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

In addition, as described below, if you or anyone in your family is determined to be disabled by the Social Security Administration ("SSA"), you must inform the Plan Administrator in a timely fashion.

Notice procedures

If you are a current Sprint employee at the time of the qualifying event, you must either provide notice of the qualifying event by contacting the Employee Help Line (EHL) through submitting an online EHL ticket in the i-Connect Web browser within 31 calendar days of the qualifying event or the loss of coverage, whichever is later.

If you are not a Sprint employee but are a qualified beneficiary, you must provide notice of the qualifying event by contacting the Plan Administrator through the Taben Group within 31 calendar days of the qualifying event or the loss of coverage, whichever is later.

Your notice must be in writing and be sent to Sprint at the following address:

The Taben Group
PO BOX 7330
Shawnee Mission, KS 66207

Your written notice must state the name of the Plan, the name and address of the employee covered under the Plan and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened. See below for additional information about notice procedures relating to disability extensions and second qualifying event extensions. Please direct all questions to the COBRA Plan Administrator.

How is COBRA coverage provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries pursuant to an election notice. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If you or your spouse or dependent children do not elect COBRA continuation coverage within the 60-day election period, as described in the election notice, you will lose your right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B or both), divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and eligible children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator in a timely fashion,
you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must notify Sprint of the disability before the date that is 60 days after the latest of: (1) the date of the SSA’s disability determination; (2) the date on which the qualifying event occurs; or (3) the date on which you would lose coverage under the Plan as a result of the qualifying event. In all cases, the notice must be provided before the end of the first 18 months of COBRA continuation coverage.

Your notice must be in writing and be sent to Sprint at the following address:

The Taben Group
PO BOX 7330
Shawnee Mission, KS 66207
Phone number: (866) 578-6459

Your written notice must include the name of the disabled qualified beneficiary, the date the qualified beneficiary became disabled and the date that the SSA made its determination. Your written notice must also include a copy of the SSA’s determination. If these notice procedures are not followed, the notice does not contain the required information or the notice is not provided to the Plan Administrator within the required period, there will be no disability extension of COBRA continuation coverage.

**Second qualifying event extension of 18-month period of COBRA continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage (or the 11-month disability extension), the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the initial qualifying event, if notice of the second qualifying event is properly given to the Plan Administrator. The notice procedures for second qualifying events are described in the election notice, and if they are not followed, then there will be no extension of COBRA continuation coverage due to a second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Shorter maximum coverage for Health Flexible Spending Account**

The maximum COBRA continuation coverage for a health flexible spending account maintained by Sprint ends on the last day of the plan year in which the qualifying event occurs.
Early termination of COBRA coverage

However, the law also provides that continuation coverage will be terminated before the end of the maximum period for any of the following five reasons:

- Sprint and all participating companies no longer provide group health coverage to any of its employees;
- The required premium for continuation coverage is not paid on time;
- After the date of your COBRA election, the qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have (in the case of a Sprint Medical Plan, the Sprint Dental Plan and the Sprint Vision Care Plan);
- After the date of your COBRA election, the qualified beneficiary becomes entitled to Medicare (in the case of a Sprint Medical Plan, the Sprint Dental Plan and the Sprint Vision Care Plan);
- The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled;
- In the case of a qualifying event involving an absence from employment by reason of military service under USERRA, the date which is the earlier of: (1) the date which is 18 months after the date on which the person is required to apply for or the return to covered employment, as determined under 38 United States Code Section 4312(e); or (2) the date which is 36 months after the date on which the absence began.

If the Plan Administrator determines that continuation coverage of a qualified beneficiary must terminate earlier than the end of the maximum period of continuation coverage applicable to such qualifying event, the Plan Administrator shall provide notice to such qualifying beneficiary as soon as practicable following the Plan Administrator’s decision. The notice shall provide: (i) the reason that continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to such qualifying event; (ii) the date of termination of continuation coverage; and (iii) any rights the qualified beneficiary may have under the Plan or under applicable law to elect an alternative group or individual coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA’s other coverage cut-off rule with these new limits as follows.

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan’s pre-existing condition rule does not apply to you by reason of HIPAA’s restrictions on pre-existing condition clauses, the Sprint Medical Plan may terminate your COBRA coverage.

If you have any questions about COBRA, please contact the EHL. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify the EHL in the manner discussed above.

If you have questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator at the following address:

Sprint Health Care Plan Administrator
Attention: Sprint Benefits
6500 Sprint Parkway
Mail Stop: KSOPHL0312-3A
Overland Park, KS 66251-1202

HIPAA privacy Notice

Notice of privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information About This Notice

Purpose

This Notice describes what Sprint Nextel Corporation, under existing federal regulations, can and cannot disclose regarding your (as used in this Notice, meaning any covered person) Protected Health Information (“PHI”) and to whom.

Plans covered

This Notice relates to the use and disclosure of your PHI by the following group health plans (“Plans”) maintained by Sprint Nextel Corporation or any of its related subsidiaries or other affiliates (“Sprint Nextel”):

- Sprint Health Account Medical/Prescription Drug Plan
- Sprint Basic Medical/Prescription Drug Plan
- Sprint Consumer Access Medical/Prescription Drug Plan
- TriCare Supplement Medical Plan
- HMO Medical/Prescription Drug Plan
- Sprint Dental Plan
- Sprint Vision Plan
- Sprint Health Care Flexible Spending Account
- Sprint Alive!
- Sprint Employee Assistance Program (GuidanceResources)
- Sprint Health Clinic
- Sprint Retiree Medical and Dental Plans

Please note that, depending on the circumstances, the term “Plans” as used in this Notice may mean multiple Plans or a single Plan. Likewise, the level of PHI that is used or disclosed may be different depending on whether the plan is fully insured through a separate health insurance provider. Your health insurance provider will notify you separately of any specific policies or procedures regarding the disclosure of PHI if your plan is fully insured.

The Plans are committed to maintaining the confidentiality of your PHI regarding coverage under the plans. This Notice describes the Plans’ legal duties and privacy practices with respect to your PHI. This Notice also describes your rights, and the Plans’ obligations, regarding the use and disclosure of your PHI.
In an effort to generally describe your rights under HIPAA (Health Insurance Portability and Accountability Act of 1996), you are being provided with a copy of this Notice as a person eligible to receive coverage under one of the Sprint Nextel-sponsored Plans. However, to the extent you are covered under one of the fully insured plans identified on the attached schedule, you may have further rights and obligations specific to that plan’s form of coverage. To the extent there is a conflict between this general Notice and the Notice provided separately by a health insurer providing fully insured benefits, the terms of the more specific Notice from the health insurer is controlling with respect to that coverage.

Who must comply
This Notice applies to:
• The Sprint Plans listed in this Notice;
• Employees or other individuals acting on behalf of the Plans; and
• Third parties performing services for the Plans.

Privacy requirements
The Plans are required by law to:
• Keep private any PHI that identifies you;
• Provide you with this Notice of the Plans’ legal duties and privacy practices with respect to your PHI; and
• Follow the terms of the Notice that is currently in effect.

General requirements
Under HIPAA, the Plans are required to maintain the privacy of your PHI. PHI is the information that is created, or received by, or on behalf of, a Plan and includes:
• Information that relates to your past, present or future physical or mental health or condition, including genetic information;
• The provision of health care to you;
• The past, present or future payment for the provision of health care to you; and
• Information that either identifies you or with respect to which there is a reasonable basis to believe the information can be used to identify you.

PHI may be maintained or transmitted either electronically or in any other form or medium. If the Plans amend this Notice for any reason, an updated privacy Notice will be provided to you.

Plans’ Use and Disclosure of Your Medical Information

General uses and disclosures
Although general use and disclosure of PHI is strictly limited, the Plans are allowed to use your PHI as follows:

Use or disclosure for payment: The Plans may use and disclose your PHI so the Plans can make proper payment for the services provided to you. For example, the Plans may use your PHI to determine your benefit eligibility or coverage level, to pay a health care provider for your medical treatment or to reimburse you for your direct payment to a health care provider.

Use or disclosure for treatment: The Plans may use and disclose your PHI to the extent necessary to facilitate your treatment. For example, the Plans may use or disclose PHI to provide, manage and coordinate health care and related services.

Use or disclosure for health care operations: The Plans may use and disclose your PHI to the extent necessary to administer and maintain the Plans. For example, the Plans may use your PHI in the process of negotiating contracts with third-party administrators, such as HMOs and provider networks, or for internal audits.

Disclosure to Sprint Nextel: With respect to your Plan coverage, the Plans may use and disclose your PHI to Sprint Nextel as permitted or required by the Plan documents, or as required by law. Certain Sprint Nextel employees who perform administrative functions for the above-described Plans may use or disclose your PHI for Plan administration purposes. Your written authorization generally is required for the Plans to disclose any PHI to Sprint Nextel for reasons other than the above-described Plan administration. At no time will PHI be disclosed to Sprint Nextel for employment-related actions or decisions.

Disclosure to Sprint Nextel: When you provide the Plans with authorization to use or disclose your PHI, you may revoke that permission, in writing, to the Privacy Official’s attention, at any time. If you revoke your authorization, the Plans will no longer use or disclose your PHI for the reasons covered by your written authorization. However, if you revoke your authorization, the Plans will be unable to reverse any disclosures already made based on your prior authorization.

Other special disclosure situations
The following are other examples of when the Plans may also disclose your PHI without your authorization:

Required by Law: The Plans may use or disclose your PHI to the extent such disclosure is required by law and the use or disclosure complies with, and is limited to, the relevant requirements of such law.

Required for Public Health: The Plans may use or disclose your PHI for public health reasons, such as the following:
• Prevention or control of disease, injury or disability;
• To report child abuse or neglect;
• To report reactions to medications or problems with products;
• To notify individuals of recalls of medications or products they may be using and track FDA regulated products as directed by the FDA; and
• To notify a person who may have been exposed to a disease, or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: As permitted or required by law, the Plans may disclose your PHI to an appropriate government authority if the Plans reasonably believe
you are the victim of abuse, neglect or domestic violence.

**Health Oversight Activities:** As required by law, the Plans may disclose your PHI to health oversight agencies. Such disclosure will occur during audits, investigations, inspections, licensure and other government monitoring and activities related to health care provision or public benefits or services.

**Judicial Proceedings, Lawsuits and Disputes:** The Plans may disclose your PHI in response to an order of a court or administrative tribunal, provided the Plans disclose only the PHI expressly authorized by such order. If you are involved in a lawsuit or a dispute, the Plans may disclose your PHI when responding to a subpoena, discovery request or other lawful process where there is no court order or administrative tribunal. Under these circumstances, the Plans will require satisfactory assurance for the party seeking your PHI that such party has made reasonable effort either to ensure you have been given notice of the request or to secure a qualified protective order.

**Law Enforcement:** In response to a court order, subpoena, warrant, summons or other legal request or upon a law enforcement official’s request, the Plans may release your PHI to a law enforcement official. The Plans may also release medical information about you to authorized government officials for purposes of public and national security.

**Coroners, Medical Examiners and Funeral Directors:** Upon your death, the Plans may release your PHI to a coroner or medical examiner for purposes of identifying you or to determine a cause of death and to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities:** The Plans may release medical information about you to authorized federal officials for intelligence, counterintelligence and any other national security activities authorized by law.

**Military and Veterans:** If you are, or were, a member of the armed forces, the Plans may release your PHI as required by military command authorities. The Plans may also release PHI about foreign military personnel to the appropriate authorities.

**Please note:** Although HIPAA generally allows use and disclosure of PHI under the conditions and circumstances described above, to the extent the laws of any state in which the plans provide coverage are more than what HIPAA generally requires, applicable laws of such state shall be followed.

### Your rights

#### You have the following rights regarding your PHI maintained by the Plans:

**Right to request restriction:** You have the right to request a restriction or limitation on the Plans’ use or disclosure of your PHI for payment or health care operations purposes as set forth above. You also have the right to request a limit on the PHI the Plans disclose about you to someone who is involved in your care or the payment of your care. The Plans are not required to agree to your request. The Plans will generally comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions on the use and disclosure of your PHI, you must complete and submit a written request on a “Request for Restrictions or Limitations Form” to the Privacy Official. Your written request must specify: (1) the information you want to limit; (2) whether you want the Plans to limit the use, disclosure or both; and (3) to whom you want the restrictions to apply.

**Right to receive confidential communications:** You have the right to ask the Plans to communicate with you about your PHI in a certain manner or at a certain location. For example, you may ask that the Plans contact you only at home and not at work. To receive confidential communications in a certain manner, you must complete and submit a written request on the “Request for Confidential Communications Form” to the Privacy Official. The Plans will accommodate all reasonable requests if you clearly state you are requesting the confidential communication because you feel disclosure could endanger your life. You must make sure your request specifies how or where you wish to be contacted.

**Right to inspect and copy your PHI:** You have the right to inspect and copy your PHI in records maintained, used, collected or disseminated by the Plans. This PHI usually includes the medical and billing records maintained by the Plans but does not include psychotherapy notes, if any, to which the Plans have access. To inspect and copy your PHI maintained by the Plans, you must submit a written request to the Privacy Official. The Plans may charge you fees for the costs of copying, mailing or other supplies directly associated with your request. If the Plans deny your request, you will have an opportunity to have the denial reviewed if the denial was based on a licensed health care professional’s opinion that:

- The access is reasonably likely to endanger the life or physical safety of you or another individual; or
- Your PHI makes references to another person, and the Plans believe that the requested access would likely cause substantial harm to the other person.

If this occurs, a licensed health care professional chosen by the Plans will review the request and denial. The person conducting the review will not be the person who denied your request. The Plans will comply with the outcome of the review.

**Right to amend your PHI:** You have the right to request an amendment to your PHI maintained by the Plans if you believe the PHI is incorrect or incomplete. To request an amendment, you must submit a written request to the Privacy Official. You must provide the Plans with a reason that supports your request.

The Plans may deny your request for an amendment in any of the following circumstances:
Your request is not in writing, or it does not include a reason to support the request;
The PHI to which your request refers was not created by the Plans, unless the person or entity that created the PHI is no longer available to make the amendment;
The PHI to which your request refers is not part of the medical information, enrollment, payment, claims adjudication or management records kept by the Plans;
The PHI to which your request refers is not part of the information you would be permitted to inspect or copy; or
The PHI to which your request refers is accurate and complete.

Right to receive an accounting of disclosures of PHI: Subject to certain exceptions, you have the right to request a list of the disclosures regarding your PHI made by the Plans. In order to receive such an accounting of disclosures, you must submit a written request to the Privacy Official. Your request must include (1) the time period for the accounting, which may not be longer than six (6) years and may not include dates prior to April 14, 2003; and (2) the form (e.g., electronic, paper) in which you would like the accounting.

Your first request within a 12-month period will be free. The Plans may charge you for costs associated with providing you additional lists. The Plans will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any costs.

Right to receive a paper copy of this Notice: You have the right to receive a paper copy of this Notice. In order to receive a paper copy, you must submit a written request to the Privacy Official. You may receive a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

Filing a complaint against the Plans
If you believe your rights have been violated, you may file a complaint with the Plans. The complaint should contain a brief description of how you believe your rights have been violated. You should attach any documents or evidence that supports your belief, along with the Plans’ Privacy Notice provided to you, or the date of such Notice. The Plans take complaints seriously. You will not be retaliated against for filing such a complaint. Please contact the Privacy Official, in care of the following contact name and address, for additional information and/or to file a complaint:

Maureen Cooney
Chief Privacy Officer
Sprint Nextel
PO Box 4600
Reston, VA 20195
(703) 433-4000

You may also file complaints with the United States Department of Health and Human Services at:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Alternatively, you may visit the HHS Web site, at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html, for more information about filing a complaint or to file a complaint electronically.

Additional Information About This Notice

Changes to this notice
The Plans reserve the right to change their privacy practices as described in this Notice. These changes may affect the use and disclosure of your PHI already maintained by the Plans, as well as any of your PHI that the Plans may receive or create in the future. The Plans will provide a copy of the current Notice to individuals currently eligible for coverage under the Plans and to new Plan enrollees at the time of enrollment. A copy of the current Notice is also available during normal business hours upon request to the Privacy Official, and on i-Connect > My Life & Career. Additionally, the Plans will provide you with any revised Notices within 60 days of material revisions to this Notice.

No guarantee of employment
Nothing in this Notice shall be construed as a contract of employment between Sprint Nextel and any employee, nor as a right of any employee to continued employment at Sprint Nextel.

No change to plans
Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Plans. You should refer to the Plan documents for complete information regarding any rights or obligations you may have under the Plans.

What You Need to Know about HIPAA and Its Impact on the Availability and Portability of Health Coverage

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal law that affects group health plans and health insurance issuers. The HIPAA provisions are designed to improve the availability and portability of health coverage by limiting exclusions for pre-existing conditions and providing individuals with special rights to enroll in health coverage when they lose their existing coverage.

To help you better understand how HIPAA affects your access to health coverage, we are providing the following brief description of some of HIPAA’s most significant provisions. We hope you find this information helpful.

Certificate of creditable coverage
Generally, you will receive a certificate of creditable coverage (a “certificate”) from a group health plan following the termination of your coverage. That way, if you subsequently become eligible under a group health plan that has pre-existing condition exclusions, you can furnish the certificate to the new plan to reduce or eliminate the exclusion. The Plans (see HIPAA Privacy Notice) will provide you a certificate of your creditable coverage in the following circumstances:

1. If you later become eligible for creditable coverage under a group health plan that has pre-existing condition exclusions.
2. If you are involuntarily terminated from your coverage.
3. If you choose to stop your coverage.
4. If you are laid off from your employment.
5. If you are involuntarily terminated from your employment.
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99. If you are involuntarily terminated from your employment.
• When health coverage terminates, in the absence of COBRA or alternative continuation coverage;
• When health coverage terminates due to the exhaustion of COBRA continuation coverage; or
• When you request, at any time within 24 months after coverage terminates by contacting the Taben Group at (866) 578-6459.

The certificate will indicate the number of days of prior creditable coverage you had in the plan since the effective date of coverage (i.e., the enrollment date). The certificate also will show coverage information for all covered members of your family. You should retain the certificate at least until the new plan has paid a claim that might otherwise be covered by a pre-existing condition exclusion.

Special enrollment periods
If you waive coverage for yourself and your eligible dependents (including your spouse) in the Sprint Medical Plan because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself or your eligible dependents (including your spouse) in medical coverage, provided that you request enrollment within 31 days after the date of a marriage or attaining domestic partner status. See applicable summary plan descriptions (SPDs) for details.
All questions about the special enrollment rights should be directed to your health care Plan Administrator.

Other important ERISA information
For more information about your rights under Employee Retirement Income Security Act (ERISA), COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, you may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep your Plan informed of address changes
In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Important Notice from Sprint About Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sprint and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to obtain Medicare prescription drug plan. If you are considering obtaining Medicare’s prescription drug coverage, you should compare your current coverage**, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Sprint has determined that the prescription drug coverage offered by each Sprint Medical/Prescription Drug Plan is, on average for all applicable plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium** (a penalty) if you later decide to join another Medicare prescription drug plan.

When Can You Join a Medicare Prescription Drug Plan?
You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from Nov. 15 through Dec. 31. However, if you lose your current creditable prescription drug coverage**, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Prescription Drug Coverage If You Decide to Join a Medicare Prescription Drug Plan?
Joining a Medicare prescription drug plan in and of itself does not affect your current Sprint coverage**.
When Will You Pay a Higher Premium (Penalty) to Join a Medicare Prescription Drug Plan?

You should also know that if you don’t join a Medicare prescription drug plan within 63 continuous days after your Sprint coverage ended**, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that creditable coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

**Note: Sprint coverage of prescription drug expenses will end for any covered person as of the later of
-- the end of the month in which such covered person becomes eligible for Medicare prescription drug coverage, and
-- the end of the month in which employee (not retiree, LTD or COBRA-continued) coverage ends,
whether or not such person is enrolled in a Medicare drug plan and whether such a person becomes eligible for Medicare prescription drug coverage by turning age 65, receipt of Social Security or Railroad Retirement Board disability or otherwise.
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<th>Benefit plan</th>
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<th>Minimum scheduled hours to be eligible</th>
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</thead>
</table>
| **The Sprint Health Account Plan (medical coverage)** | Administered nationwide by **UnitedHealthcare**  
Phone: (800) 228-0194  
Account #: 712603  
Internet: myuhc.com  
i-Connect > My Life & Career | 20 hours | **Existing employees**  
Enroll during the fall Annual Enrollment window  
Effective Jan. 1, 2013  
**Newly hired and re-hired employees**  
Enroll within 30 calendar days after hire/re-hire date  
Effective on the 31st calendar day after hire/re-hire date |
| **Sprint Basic Plan and Sprint Consumer Access Plan (medical coverage)** | Administered nationwide by BlueCross BlueShield of Illinois  
Phone: (877) 284-1571  
Account #: 639300 for most states  
Internet: www.bcbsil.com/sprint  
i-Connect > My Life & Career | 20 hours | **Existing employees**  
Enroll during the fall Annual Enrollment window  
Effective Jan. 1, 2013  
**Newly hired and re-hired employees**  
Enroll within 30 calendar days after hire/re-hire date  
Effective on the 31st calendar day after hire/re-hire date |
| **Health Savings Account (option available exclusively with the Sprint Basic Plan)** | ACS|BNY Mellon  
Phone: (877) 635-5472  
Internet: https://hsamember.com/HSA/advantagedirect?hpp=002  
i-Connect > My Life & Career | 20 hours | **Existing employees**  
For full Sprint contribution, elect to contribute funds during fall Annual Enrollment window and set up account by Jan. 31, 2013, using contact information to the left  
Paysroll deductions effective Jan. 1, 2013; Sprint funds deposited in equal allocations in 24 paychecks across 2013  
**Newly hired and re-hired employees**  
You may start, stop or change the amount of your Sprint HSA payroll deduction contribution throughout the year (not just during qualifying “Life Events” as with most other Sprint benefits). Your HSA payroll deductions are effective as of the first of the month after the effective date of your election (January 1 for Annual Enrollment). |
| **Prescription drug coverage for Sprint Basic Plan, Sprint Consumer Access Plan and Sprint Health Account Plan (Note: Coverage may vary by plan)** | CVS Caremark  
Phone: 855-848-9165.  
Internet: www.caremark.com  
i-Connect > My Life & Career | 20 hours | **Existing employees**  
Automatically enrolled when you enroll in a national Medical/Prescription Drug plan during fall Annual Enrollment window  
Effective Jan. 1, 2013  
**Newly hired and re-hired employees**  
Automatically enrolled when you enroll in a national Medical/Prescription Drug plan during your enrollment window  
Effective on the 31st calendar day after hire/re-hire date |
| **HMOs** | **Kaiser Permanente**  
i-Connect > My Life & Career | 20 hours | **Existing employees**  
Enroll during the fall Annual Enrollment window  
Effective Jan. 1, 2013  
**Newly hired and re-hired employees**  
Enroll within 30 calendar days after hire/re-hire date  
Effective on the 31st calendar day after hire/re-hire date |
| **TRICARE Supplement Plan** | **ASI**  
Phone: 800-638-2610, ext. 255  
Website: www.asicorporation.com | 20 hours | **Existing employees**  
Enroll during the fall Annual Enrollment window  
Effective Jan. 1, 2013  
**Newly hired and re-hired employees**  
Enroll within 30 calendar days after hire/re-hire date  
Effective on the 31st calendar day after hire/re-hire date |
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<th>Benefit plan</th>
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<th>When to enroll and when effective</th>
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<tr>
<td><strong>Dental Plan</strong></td>
<td>Delta Dental of Kansas, Inc.</td>
<td>20 hours</td>
<td><strong>Existing employees</strong>*&lt;br&gt;Enroll during the fall Annual Enrollment window&lt;br&gt;Effective Jan. 1, 2013&lt;br&gt;&lt;br&gt;<strong>Newly hired and re-hired employees</strong>&lt;br&gt;Enroll within 30 calendar days after hire/re-hire date&lt;br&gt;Effective on the 31st calendar day after hire/re-hire date</td>
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<td><strong>Vision Plan</strong></td>
<td>Surency Vision</td>
<td>20 hours</td>
<td><strong>Existing employees</strong>*&lt;br&gt;Enroll during the fall Annual Enrollment window&lt;br&gt;Effective Jan. 1, 2013&lt;br&gt;&lt;br&gt;<strong>Newly hired and re-hired employees</strong>&lt;br&gt;Enroll within 30 calendar days after hire/re-hire date&lt;br&gt;Effective on the 31st calendar day after hire/re-hire date</td>
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<td><strong>Flexible Spending Accounts (FSAs) – Health Care and Dependent Care</strong></td>
<td>ADP Benefit Services</td>
<td>20 hours</td>
<td><strong>Existing employees</strong>*&lt;br&gt;Enroll during the fall Annual Enrollment window&lt;br&gt;Effective Jan. 1, 2013&lt;br&gt;&lt;br&gt;<strong>Newly hired and re-hired employees</strong>&lt;br&gt;Enroll within 30 calendar days after hire/re-hire date&lt;br&gt;Effective on the 31st calendar day after hire/re-hire date</td>
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<td><strong>Life Insurance and AD&amp;D</strong></td>
<td>Employee Help Line</td>
<td>20 hours</td>
<td><strong>Existing employees</strong>*&lt;br&gt;Enroll during the fall Annual Enrollment window&lt;br&gt;Effective Jan. 1, 2013&lt;br&gt;&lt;br&gt;<strong>Newly hired and re-hired employees</strong>&lt;br&gt;Enroll within 30 calendar days after hire/re-hire date&lt;br&gt;Effective on the 31st calendar day after hire/re-hire date</td>
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<td><strong>Disability Coverage – Short-Term Disability (STD) and Long-Term Disability (LTD)</strong></td>
<td>Employee Help Line</td>
<td>20 hours</td>
<td><strong>Existing employees</strong>*&lt;br&gt;Company-funded STD and LTD (50% level) automatically provided&lt;br&gt;&lt;br&gt;<strong>Newly hired and re-hired employees</strong>&lt;br&gt;Enroll in additional LTD coverage during the fall Annual Enrollment window&lt;br&gt;Effective Jan. 1, 2013, or after one year of employment (whichever is later)</td>
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<td><strong>Group Legal Plan</strong></td>
<td>Hyatt Legal</td>
<td>20 hours</td>
<td><strong>Existing employees</strong>*&lt;br&gt;Enroll during the fall Annual Enrollment window&lt;br&gt;Effective Jan. 1, 2013&lt;br&gt;&lt;br&gt;<strong>Newly hired and re-hired employees</strong>&lt;br&gt;Enroll within 30 calendar days after hire/re-hire date&lt;br&gt;Effective on the 31st calendar day after hire/re-hire date</td>
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*For Unum Individual Short-Term Disability coverage, please see page 77.*
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<td><strong>Sprint Alive!</strong></td>
<td><strong>Sprint Alive!</strong>&lt;br&gt;Phone: (866) 90-ALIVE (25483)&lt;br&gt;Or dial *545 on your Sprint phone&lt;br&gt;Internet: <a href="http://www.sprintalive.com">www.sprintalive.com</a>&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>20 hours</td>
<td><strong>Existing employees</strong>*&lt;br&gt;No enrollment necessary&lt;br&gt;Can use anytime</td>
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<td><strong>Employee Assistance Program (GuidanceResources)</strong></td>
<td><strong>ComPsych/GuidanceResources</strong>&lt;br&gt;Phone: (888) 303-3957&lt;br&gt;Internet: <a href="http://www.guidanceresources.com">www.guidanceresources.com</a>&lt;br&gt;Company ID: SPRINT&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>20 hours</td>
<td><strong>Newly hired and re-hired employees</strong>*&lt;br&gt;No enrollment necessary&lt;br&gt;Can use anytime</td>
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<td><strong>Sprint Nextel 401(k) Plan</strong></td>
<td><strong>Fidelity</strong>&lt;br&gt;Phone: (800) 877-4015&lt;br&gt;Internet: <a href="http://www.netbenefits.com/sprint">www.netbenefits.com/sprint</a>&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>No minimum</td>
<td>Enroll at any time&lt;br&gt;Participation begins after enrollment complete</td>
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<tr>
<td><strong>Employees Stock Purchase Plan</strong></td>
<td><strong>Fidelity</strong>&lt;br&gt;Phone: (800) 877-4015&lt;br&gt;Internet: <a href="http://www.netbenefits.com/sprint">www.netbenefits.com/sprint</a>&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>20 hours</td>
<td>Enrollment opens quarterly (four times a year)&lt;br&gt;Participation begins after enrollment is complete and new quarter begins</td>
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<td><strong>Financial Planning</strong></td>
<td><strong>Ameriprise Financial Services</strong>&lt;br&gt;Phone: (800) 437-3500&lt;br&gt;Internet: <a href="http://www.ameriprise.com/sprint">www.ameriprise.com/sprint</a>&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>No minimum</td>
<td>No enrollment necessary&lt;br&gt;Can use anytime</td>
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<td><strong>Individual Short-Term Disability coverage</strong></td>
<td><strong>UNUM</strong>&lt;br&gt;(888) 693-1388 (option 7)&lt;br&gt;<a href="https://sprint.benefithub.com/?refer=JZSGVF">https://sprint.benefithub.com/?refer=JZSGVF</a></td>
<td>20 hours</td>
<td>Enroll at any time with completion of medical questionnaire&lt;br&gt;Coverage effective upon approval date&lt;br&gt;Enroll within 30 calendar days after hire/re-hire date&lt;br&gt;Coverage effective on the first of the month following 60 days of employment. Note: You will receive the plan and coverage amount applied for on the application, unless it is determined to be unacceptable under Unum rules, limits and standards. In such event, the plan and coverage amount may be modified or declined.</td>
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<td>Benefit plan</td>
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</tr>
<tr>
<td>Critical Illness Insurance</td>
<td>MetLife</td>
<td>20 hours</td>
<td>Enroll within 31 days of hire date</td>
</tr>
<tr>
<td></td>
<td>(888) 693-1388</td>
<td></td>
<td>Coverage effective on the first of the month following 60 days of</td>
</tr>
<tr>
<td></td>
<td>(option 6)</td>
<td></td>
<td>employment</td>
</tr>
<tr>
<td></td>
<td><a href="https://sprint.benefithub.com/?refer=JZSGVF">https://sprint.benefithub.com/?refer=JZSGVF</a></td>
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</tr>
<tr>
<td>Universal Life Insurance</td>
<td>Allstate Benefits</td>
<td>20 hours</td>
<td>Enroll at any time with completion of medical questionnaire</td>
</tr>
<tr>
<td></td>
<td>(888) 693-1388</td>
<td></td>
<td>Coverage effective upon approval date</td>
</tr>
<tr>
<td></td>
<td>(option 4)</td>
<td></td>
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<tr>
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<td><a href="https://sprint.benefithub.com/?refer=JZSGVF">https://sprint.benefithub.com/?refer=JZSGVF</a></td>
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</tr>
<tr>
<td>Long-Term Care Insurance</td>
<td>Unum</td>
<td>20 hours</td>
<td>Enroll at any time with completion of medical questionnaire</td>
</tr>
<tr>
<td></td>
<td>(888) 693-1388</td>
<td></td>
<td>Coverage effective the first of the month in which the first payroll</td>
</tr>
<tr>
<td></td>
<td>(option 2)</td>
<td></td>
<td>deduction occurs</td>
</tr>
<tr>
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</tr>
<tr>
<td>Auto and Home Insurance</td>
<td>Liberty Mutual, MetLife Auto &amp; Home and Travelers</td>
<td>20 hours</td>
<td>Enroll year-round</td>
</tr>
<tr>
<td></td>
<td>(888) 693-1388</td>
<td></td>
<td>Coverage effective upon approval date</td>
</tr>
<tr>
<td></td>
<td>(option 1)</td>
<td></td>
<td></td>
</tr>
<tr>
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</tr>
<tr>
<td>Pet Insurance</td>
<td>VPI Pet Insurance</td>
<td>20 hours</td>
<td>Enroll year-round</td>
</tr>
<tr>
<td></td>
<td>(888) 693-1388</td>
<td></td>
<td>Coverage effective upon approval date</td>
</tr>
<tr>
<td></td>
<td>(option 3)</td>
<td></td>
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<tr>
<td>Group Accident Insurance</td>
<td>Aflac</td>
<td>20 hours</td>
<td>Enroll year-round</td>
</tr>
<tr>
<td></td>
<td>(888) 693-1388</td>
<td></td>
<td>Coverage effective on the first of the month following 60 days of</td>
</tr>
<tr>
<td></td>
<td>(option 8)</td>
<td></td>
<td>employment</td>
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<tr>
<td></td>
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<tr>
<td>Rewards and Recognition</td>
<td><a href="http://www.sprint.com/irecognize">www.sprint.com/irecognize</a></td>
<td>No minimum</td>
<td>Available year-round</td>
</tr>
<tr>
<td>Employee Phone Programs</td>
<td>i-Connect &gt; My Life &amp; Career</td>
<td>20 hours</td>
<td>Available year-round</td>
</tr>
<tr>
<td>Sprint Employee Discount Site</td>
<td>Sprint MarketPlace</td>
<td>No minimum</td>
<td>Available year-round</td>
</tr>
</tbody>
</table>

*Existing employees*

*Newly hired and re-hired employees*
<table>
<thead>
<tr>
<th>Benefit plan</th>
<th>Contact details</th>
<th>Minimum scheduled hours to be eligible</th>
<th>When to enroll and when effective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retiree Medical/Dental</strong></td>
<td>Sprint Retirement Services: (866) 333-7311&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>Age 55 or older, 10 years of service or greater, and regularly scheduled to work at least 20 hours per week at time of retirement</td>
<td>Enroll at retirement if applicable</td>
</tr>
<tr>
<td><strong>Paid Time Off / Holidays</strong></td>
<td>i-Connect &gt; My Life &amp; Career</td>
<td>20 hours (prorated) for PTO</td>
<td>PTO available year-round (check PTO policy on i-Connect)</td>
</tr>
<tr>
<td><strong>Leaves of Absence</strong></td>
<td>i-Connect &gt; My Life &amp; Career</td>
<td>20 hours</td>
<td>Refer to Employee Guide</td>
</tr>
<tr>
<td><strong>Business Travel Accident Insurance</strong></td>
<td>The Hartford&lt;br&gt;Phone: (888) 563-1124 (toll-free from the U.S. or Canada)&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>20 hours</td>
<td>No enrollment necessary (automatically covered if eligible)</td>
</tr>
<tr>
<td><strong>Travel Assistance Program</strong></td>
<td>The Hartford&lt;br&gt;(888) 563-1124 (toll-free from the U.S. or Canada)&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>20 hours</td>
<td>No enrollment necessary (automatically covered if eligible)</td>
</tr>
<tr>
<td><strong>Medical Benefits Abroad</strong></td>
<td>Cigna International&lt;br&gt;Phone: (800) 243-1348 (inside U.S. and Canada)&lt;br&gt;i-Connect &gt; My Life &amp; Career</td>
<td>40 hours</td>
<td>No enrollment necessary (automatically covered if eligible)</td>
</tr>
<tr>
<td><strong>Adoption Assistance Program</strong></td>
<td>i-Connect &gt; My Life &amp; Career</td>
<td>30 hours</td>
<td>Available year-round</td>
</tr>
<tr>
<td><strong>Matching Gift Program</strong></td>
<td>Intranet: type “matching” into you Web browser</td>
<td>20 hours</td>
<td>Available year-round</td>
</tr>
<tr>
<td><strong>Sprint Volunteers Program</strong></td>
<td>sprint.com/volunteers</td>
<td>No minimum</td>
<td>Available year-round</td>
</tr>
<tr>
<td><strong>Employee Help Line</strong></td>
<td>(800) 697-6000&lt;br&gt;Intranet: type “ehlticket” into your Web browser</td>
<td>No minimum</td>
<td>Available for employee questions</td>
</tr>
</tbody>
</table>