Employee Benefits Guide for the Group Health and Welfare Benefits Plan for Employees of Envoy Air Inc. and Its Affiliates

Effective January 1, 2016

About This Guide

Envoy Air, Inc. (the "Company") provides you with a comprehensive benefits package designed to help you meet the health, life, accident, disability, and dependent care needs of you and your eligible family members. To help you make the most of those benefits, this Employee Benefits Guide (the "Guide" or "EBG") describes the provisions of the Group Health and Welfare Benefits Plan for Employees of Envoy Air Inc. and Its Affiliates (the "Plan") effective January 1, 2016.

This Guide provides a comprehensive overview of the benefits available under the Plan as well as limitations, exclusions, Deductible and Co-Insurance requirements. A detailed list of benefit types provided under the Plan, along with contact information, can be found in the chapter "Reference Information." The provisions of this Guide apply to eligible employees on the United States payroll, spouses, Company Recognized Domestic Partners, dependents, and surviving spouses who elect coverage of the Company, Eagle Aviation Services, Inc., and Executive Airlines, Inc. (collectively, the "Affiliates"). The provisions of this Guide do not apply to employees of Executive Ground Services, Inc. Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

This Guide serves as the summary plan description for the Plan. This Guide provides a comprehensive overview of the benefits available under the Plan as well as limitations, exclusions, Deductible and Co-Insurance requirements. A detailed list of benefit types provided under the Plan, along with contact information, can be found in the chapter "Benefits under the Plan and Contact Information."

The terms and conditions of the Plan are set forth in this Guide, the formal Plan Document, and insurance policies/evidence of coverage related to the benefits under the Plan. Together, these documents are incorporated by reference into the formal Plan Document and constitute the written instruments under which the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan. In our efforts to provide you with full multi-media access to benefits information, the Company has created an online version of this Guide. A paper version of this Guide will be available to you at no charge, upon request.

Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and an insurance policy/evidence of coverage, or this Guide, the Plan Document controls. If the Plan Document is silent, then the Guide controls, except where the Guide refers to an insurance policy/evidence of coverage. If both the Plan Document and Guide are silent, the terms of the applicable insurance policy/evidence of coverage controls. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or insurance policy/evidence of coverage control when describing specific benefits that are covered or insurance-related terms. If there is any discrepancy between the online version and this Guide, then the benefits outlined in this Guide, plus the official notices of changes to the Plan, will govern. See the chapter " Reference Information" to determine whether a particular benefit is self-funded by the Company or fully insured by the insurer. In the event of a conflict between the Plan's provisions contained in this Guide and the provisions contained in any applicable collective bargaining agreement, the collective bargaining agreement shall govern in all cases with respect to employees covered by such agreement.

The Company reserves the right to modify, amend or terminate the Plan, any of the Plan's benefits, any program described in this Guide, or any part thereof, at its sole discretion. You will be notified of any changes that affect your benefits, as required by federal law.

Only the Company or the Envoy Benefits Administration Committee ("EBAC") is authorized to change the Plan. From time to time, you may receive updated information concerning changes to the Plan. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment, or benefits of any kind.

Contents

Benefits at a Glance ... **7**
General Eligibility ... **10**
Ineligibility ... *14*
Dependent Eligibility ... *14*
Determining a Child's Eligibility ... *17*
Proof of Dependent Eligibility ... *18*
Determining a Spouse, Common Law Spouse, or Domestic Partner's Eligibility ... *19*
Special Rules That Apply To Employees Married to Other Employees ... *21*
How to Enroll ... *27*
Coverage Levels ... *27*
When Coverage Begins ... *27*
Paying for Coverage ... *28*
Coverage Under the Plan While on a Family and Medical Leave, Unpaid Sick or Injury on Duty Leave, or a Military Leave ... *31*
Life Events and Special Enrollment Rights: Making Changes During the Year ... **35**
Table of Life Events and Permitted Benefit Changes ... *39*
Special Life Event Considerations ... *52*
Benefit Coverage Affected by Life Events ... *53*
Benefit Coverage Not Affected by Life Events ... *53*
Medical Benefits Overview ... **54**
Key Features of the Medical Benefits Options ... *58*
Medical Benefit Options Comparison ... *59*
Health Maintenance Organizations (HMOs) ... *90*
Prior Authorization and Pre-Determination for Certain Medical Services ... *92*
Pre-Authorization ... *93*
Covered Expenses ... *96*
Mental Health and Chemical Dependency Benefits ... *104*
Prescription Drug Benefits ... *105*
Mail Service Prescription Drug Option ... *110*
Excluded Expenses ... *112*
Filing Claims ... *116*
Claims Filing Deadline ... *116*
Employee Assistance Program (EAP) ... **118**
The Legal Plan Benefit ... **119**
Critical Illness Benefit ... **120**
Dental Benefits ... **126**
How the Dental Benefit Option Works ... *126*
Covered Expenses ... *127*
Excluded Expenses ... *129*
Filing Claims ... *130*
Additional Rules ... *131*
Vision Benefits ... **132**
EyeMed Vision Discount Plan ... *132*
EyeMed Vision Insurance Plan ... *132*
Life Insurance Benefits ... **134**
Employee Term Life Insurance ... *133*
Spouse and Child Term Life Insurance Benefits ... *136*
Accident Insurance Benefit ... **140**
Accidental Death & Dismemberment Insurance ... *140*
Covered Losses and Accident Benefits ... *141*
Terrorism and Hostile Act AD&D Insurance for Pilots and Flight Attendants ... *147*
Exclusions ... *149*
Filing a Claim ... *149*

Conversion Rights 150
Insurance Policy 150
Other Accident Insurance 150
Disability Benefits **155**
Optional Short Term Disability Insurance 154
Long Term Disability Insurance 158
Health Care FSA **168**
Enrolling in a Flexible Spending Account 168
How the Health Care FSA Works 169
Who Is Covered 169
Eligible Expenses 169
Excluded Expenses 171
Receiving Reimbursement 172
2-1/2 Month Carryover of Unused HCFSA Funds 174
Continuation of Coverage 174
Dependent Day Care FSA **175**
Enrolling in the DDFSA 175
How the DDFSA Works 175
Conditions for Deposit and Maximum Allowable Deposit Amounts 176
Who Is Covered 176
DDFSA Guidelines 177
Eligible Expenses 177
Receiving Reimbursement 177
Filing Claims 178
2-1/2 Month Carryover of Unused DDFSA Funds 179
Additional Health Benefit Rules **180**
Qualified Medical Child Support Order 180
Procedures Upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice 181
Procedures Upon Final Determination 183
Coordination of Benefits 183
Coordination with Medicare 185
Continuation of Coverage — COBRA Continuation 186
How to Elect COBRA Continuation of Coverage 188
Enrolling in COBRA Continuation of Coverage 189
Processing Life Events After COBRA Continuation of Coverage Is in Effect 189
Paying for or Discontinuing COBRA Continuation of Coverage 190
Other Special Rules 191
Surviving Spouses of Active Employees 191
Additional Life and Accident Insurance Rules **193**
Beneficiaries 193
Taxation of Life Insurance 194
Portability and Conversion 196
Verbal Representations 197
Assignment of Benefits 197
Total Control Account 197
Plan Administration **198**
Plan Information 198
Administrative Information 199
Plan Amendments 199
Plan Funding 200
Collective Bargaining Agreement 201
Claims & Appeals Procedures 202
Assignment of Benefits 204
Time Frame for Initial Claim Determination 204
Appealing a Denial 210

Compliance with Privacy Regulations 219
Organized Health Care Arrangement 223
Your Rights Under ERISA 234
Reference Information **237**
Contact Information 237
Glossary 240
Archives 253

Benefits at a Glance

The Plan will include the following benefits for 2016:

Type of Benefit	Self-Funded or Insured	Administrator or Insurer	Funding Mechanism
MEDICAL BENEFIT			
PPO 750 Option	Self-funded	BCBS	Company and Employee Contributions, and General Assets of the Company
PPO 1500 Option	Self-funded	BCBS	Same as above
PPO 2500 Option	Self-funded	BCBS	Same as above
Out of Area Option	Self-funded	BCBS	Same as above
HMO (PR, USVI)	Insured	Triple-S Salud	Company and Employee Premiums
DENTAL BENEFIT	Self-funded	MetLife	Company and Employee Contributions
VISION BENEFIT			
Vision Insurance	Insured	EyeMed	Employee Contributions
LIFE INSURANCE			
Employee Basic Life*	Insured	The Hartford	Company Premiums
Employee Voluntary Life	Insured	The Hartford	Employee Premiums
Spouse Life	Insured	The Hartford	Employee Premiums
Child Life	Insured	The Hartford	Employee Premiums
AD&D INSURANCE			
Basic AD&D*	Insured	LINA (Cigna)	Company Premiums
VPAI	Insured	LINA (Cigna)	Employee Premiums
MPAI	Insured	LINA (Cigna)	Company Premiums
Special Purpose	Insured	LINA (Cigna)	Company Premiums
Special Risk	Insured	LINA (Cigna)	Company Premiums
Terrorism and Hostile Act Accident Insurance	Insured	LINA (Cigna)	Company Premiums

Type of Benefit	Self-Funded or Insured	Administrator or Insurer	Funding Mechanism
DISABILITY INSURANCE			
Optional Short Term Disability	Insured	The Hartford	Employee Premiums

Type of Benefit	Self-Funded or Insured	Administrator or Insurer	Funding Mechanism
Long Term Disability	Insured	The Hartford	Employee Premiums
FLEXIBLE SPENDING ACCOUNTS (FSAs)			
Health Care FSA	Self-funded	Aon Hewitt	Employee Contributions
Dependent Day Care FSA	Self-funded	Aon Hewitt	Employee Contributions
CRITICAL ILLNESS	Insured	AllState	Employee Premiums
EMPLOYEE ASSISTANCE PROGRAM	Self-Funded	EAP Consultants, LLC	General Assets of the Company
LEGAL SERVICES	Insured	Metlaw/Hyatt	Employee Contributions

*You must be enrolled in a Company-sponsored Medical option to be eligible for Basic Life insurance and Basic AD&D insurance.

General Eligibility

Eligible Employees

As a regular employee on the U. S. payroll of the Company or an Affiliate, you are eligible for Company subsidized health benefits when you have completed one month of employment at the Company. Please note that special rules apply for Fleet Service Clerks, Agents and Flight Attendants that are described below.

If you enroll by the enrollment deadline, your selected coverage is retroactive to your one month employment date and your paycheck is adjusted as necessary. Coverage under the Plan will not begin until: (i) you have reported to your first day of work, and (ii) except as otherwise noted, you are "actively-at-work." Unless otherwise provided in the applicable insurance policy/evidence of coverage, "actively-at-work" means you are at work and performing all of the regular duties of your job.

The "actively-at-work" requirement does not apply to the Medical Benefit Options if the reason you are not actively-at-work is due to a health condition; in that event, your coverage under the Medical Benefit Option is effective after one month of seniority as long as you have reported to your first day of work.

If you do not enroll for coverage when you are first eligible for benefits, you will receive no coverage. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

For coverage requiring proof of good health, coverage becomes effective only after coverage is approved and your first contributions are paid by you through payroll deductions.

Shortly following the start of employment at the Company, you will be able to enroll online at the Benefits Service Center. For more information about enrollment, see *General Enrollment*.

Hours Worked Requirement for Fleet Service Clerks and/or Agents

Newly Hired Employees

Effective January 1, 2015, newly hired employees will be eligible to enroll in benefits after one month of employment and will continue to be eligible for benefits through the end of the year in which the second anniversary of their start date occurs. Thereafter, they will be treated as "ongoing employees" and their eligibility and contribution rates will be determined based on their Eligible Hours during the period from October 3rd to October 2nd of the preceding year (the "Look Back Period"). For example, a Fleet Service Clerk or Agent hired on March 3, 2015 will be eligible for benefits on April 3, 2015 and will remain eligible through December 31, 2017. The annual analysis of Eligible Hours performed prior to the annual enrollment occurring in fall 2017 will review the Eligible Hours credited from October 3, 2016 through October 2, 2017 to determine eligibility for coverage during 2018.

With respect to contribution rates for newly hired employees, the following rules apply:

- From the date of hire through the end of that calendar year, employees will pay the rate according to their hire classification (e.g., Part-time or Full-time).
- For the calendar year following the date of hire, employees who are hired after July 3rd (i.e., less than 3 months before the Look Back Period) will continue to pay the contribution rate according to their hire classification.
- For the calendar year following the date of hire, employees who are hired on or before July 3rd (i.e., 3 or more months before the Look Back Period) will have their Eligible Hours prorated to determine the contribution rate for the next year.

For example, a Fleet Service Clerk or Agent hired on August 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015 and 2016. In contrast, a Fleet Service Clerk or Agent hired on March 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015, and the rate for 2016 will be determined based on whether he/she was full-time or part-time based on a prorated number of hours worked from March 3, 2015 through October 2, 2015. In both examples, the Fleet Service Clerk or Agent's contribution rate for 2017 will be based on the Eligible Hours worked during the October 3, 2015 through October 2, 2016 Look Back Period.

"Eligible Hours" shall include all paid work hours, paid sick, paid vacation, Union Business Paid, Union Business Comp, paid Injury on Duty leave, and paid/unpaid Family Medical Leave of Absence (FMLA). Unpaid time off from work is not included in the calculation of "paid hours" for purposes of determining eligibility, except as noted above and in the paragraph below entitled "Break in Service for Agents, Fleet Service Clerks, and Flight Attendants."

Ongoing Employees

Effective with the Plan year beginning January 1, 2014, after the second anniversary of their start date, Fleet Service Clerks and Agents must have worked 800 or more Eligible Hours during the Look Back Period to be eligible for coverage under the Plan. For example, the annual analysis of Eligible Hours performed prior to the annual enrollment occurring in fall 2015 (for the 2016 calendar year) will review the Eligible Hours credited from October 3, 2014 through October 2, 2015. Any Fleet Service Clerk or Agent who meets the appropriate Eligible Hours requirement during the Look Back Period will be eligible to enroll in benefits during the annual enrollment period for coverage during 2016.

Fleet Service Clerks and Agents who worked between 800 and 1559 Eligible Hours during the Look Back Period will be eligible for Company-subsidized health benefits at the part-time employee contribution rate. Fleet Service Clerks and Agents who worked 1,560 or more Eligible Hours during the Look Back Period will be eligible for Company-subsidized health benefits at the full-time employee contribution rate.

Hours Worked Requirement for Flight Attendants

Newly Hired Employees

Effective January 1, 2015, newly hired employees will be eligible to enroll in benefits after one month of employment and will continue to be eligible for benefits through the end of the year in which the second anniversary of their start date occurs. Thereafter, they will be treated as "ongoing employees" and their eligibility and contribution rates will be determined based on their Flight

Attendant Eligible Hours during the Look Back Period. For example, a Flight Attendant hired on March 3, 2015 will be eligible for benefits on April 3, 2015 and will remain eligible through December 31, 2017. The annual analysis of Flight Attendant Eligible Hours performed prior to the annual enrollment occurring in fall 2017 will review the Flight Attendant Eligible Hours credited from October 3, 2016 through October 2, 2017 to determine eligibility for coverage during 2018.

With respect to contribution rates for newly hired employees, the following rules apply:

- From the date of hire through the end of that calendar year, employees will pay the rate according to their hire classification.
- For the calendar year following the date of hire, employees who are hired after July 3rd (i.e., less than 3 months before the Look Back Period ends) will continue to pay the rate according to their hire classification for that year.
- For the year following the date of hire, employees who are hired on or before July 3rd (i.e., 3 or more months before the Look Back Period ends) will have their Flight Attendant Eligible Hours prorated to determine the contribution rate for the next year.

For example, a Flight Attendant hired on August 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015 and 2016. In contrast, a Flight Attendant hired on March 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015, and the rate for 2016 will be determined based on the prorated number of Flight Attendant Eligible Hours credited from March 3, 2015 through October 2, 2015. In both examples, the Flight Attendant's contribution rate for 2017 will be based on the Flight Attendant Eligible Hours worked during the October 3, 2015 through October 2, 2016 Look Back Period. "Flight Attendant Eligible hours" are outlined in the applicable Collective Bargaining Agreement.

Ongoing Employees

Effective with the Plan year beginning January 1, 2014, after the second anniversary of their start date, Flight Attendants that worked between 350 and 539 Flight Attendant Eligible Hours during the Look Back Period, prorated in accordance with the applicable Collective Bargaining Agreement, will be eligible for Company-subsidized health benefits at the part-time employee contribution rate. Flight Attendants who worked 540 or more Flight Attendant Eligible Hours during the Look Back Period will be eligible for Company-subsidized health benefits at the full-time employee contribution rate. For example, the annual analysis of Flight Attendant Eligible Hours performed prior to the annual enrollment occurring in fall 2014 (for the 2015 calendar year) will review the Flight Attendant Eligible Hours credited from October 3, 2013 through October 2, 2014. Any Flight Attendant who meets the appropriate Flight Attendant Eligible Hours requirement during the Look Back Period will be eligible to enroll in benefits during the annual enrollment period for coverage during 2015.

Break in Service for Agents, Fleet Service Clerks, and Flight Attendants

If you terminate employment but are rehired, you will be treated as a New Hire, except if you are rehired within 13 weeks of your termination date, you will not be subject to the one month waiting period.

Eligibility After Age 65

As an active employee, your medical coverage continues for you and your covered dependents after you reach age 65 (or your spouse reaches age 65), unless you (or your spouse) opt out of the Plan.

If you elect Medicare as your only coverage, your Company-sponsored medical coverage will terminate, including coverage for your dependents. If your spouse elects Medicare as his or her only coverage, your spouse's Company-sponsored coverage will terminate.Ineligibility

None of the following individuals are eligible to participate in this benefits program:

- Intern;
- A leased employee, as defined in section 414(n) of the Internal Revenue Code;
- Any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service, or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker; this term includes any of the following former classifications:
  - temporary employee. If a temporary employee becomes a Regular Employee, he/she must meet all of the other requirements to participate in the Plan;
  - provisional employee;
  - associate employee;
- An independent contractor;
- Employees of Executive Ground Services, Inc.; or
- Any person:
  - who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion);
  - who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate;
  - who tells the Company he/she is an independent contractor, or is employed by another company while providing services to the Company, even if the worker is, or may be reclassified at a later date as, an employee of the Company by the courts, the IRS or the DOL; or
  - whose compensation is reported to the Internal Revenue Service on a form other than a Form W-2, regardless of whether such person was treated as an employee for federal income tax purposes.

Dependent Eligibility

Dependent eligibility requirements are different depending on the benefit coverage you elect.

Medical Coverage

An eligible dependent is an individual who lives in the United States, Puerto Rico, or U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse,.

- Company-recognized Domestic Partners and their children are not eligible to participate in Flexible Spending Accounts. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).**
- Child under age 26. See “Determining a Child’s Eligibility” below for who qualifies as a “child.”
    - Step-children.
    - Legally adopted children.
    - Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.
- Incapacitated child age 26 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.

Coverage for an Incapacitated Child – Medical Coverage Only

An “incapacitated child” age 26 or older is eligible for continuation of coverage if all of the following criteria are met:

- The child was already continuously covered as your dependent under this Plan before reaching age 26
- The child is mentally or physically incapable of self-support.
- You file a Statement of Eligibility for Incapacitated Child and your network/claims administrator approves the application.
    - For Blue Cross and Blue Shield of Texas: Within 45 days of the date coverage would otherwise end.
    - For HMOs: Contact your HMO for the time limit
- The child continues to meet the criteria for dependent coverage under this Plan.
- You provide additional medical proof of incapacity as may be required by your network/claims administrator from time to time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your network/claims administrator determines the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate it.
- And either the child maintains legal residence with you and is wholly dependent on you for maintenance and support, or you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency).

Dental and Vision Coverage

An eligible dependent is an individual (other than the employee covered by the Plan) who lives in the United States, Puerto Rico, or U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, Company-recognized Domestic Partner or common law spouse. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).**

- Unmarried "child" under age 23 who maintains legal residence with you. See "Determining a Child's Eligibility" below for who qualifies as a "child."
- Stepchild, under the age 23, if the child lives with you, and you (the employee) either jointly or individually claim the stepchild as a dependent on your federal income tax return
- Child, under age 23, for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Child Life Insurance and Child Accidental Death and Dismemberment (AD&D) Insurance

An eligible dependent is an individual (other than the employee covered by the Plan) who lives in the United States, Puerto Rico, or U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. Child means the following:

- Incapacitated child age 19 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the child of a Company-recognized Domestic Partner) who is:
  - under age 19 unmarried and supported by you; or
  - under age 23 and who is:
    - a full-time student at an accredited school, college or university that is licensed in the
      - jurisdiction where it is located;
      - unmarried;
      - supported by you; and
      - not employed on a full-time basis.

The term does not include any person who:

- Is in the military of any country or subdivision of any country; or
- Is insured under the Group Policy as an employee.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

For Texas residents, Child means the following for Life Insurance:

- Your natural child, adopted child or stepchild (including the child of a Company-recognized Domestic Partner) who is under age 25 and unmarried.

The term also includes:

- Your grandchild who is under age 25, unmarried and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Life Insurance.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

The term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is insured under the Group Policy as an employee.

Spouse Life Insurance and Spouse Accidental Death and Dismemberment (AD&D) Insurance

An eligible dependent is an individual (other than the employee covered by the Plan) who lives in the United States, Puerto Rico, or U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, Company-recognized Domestic Partner or common law spouse, not employed by the Company.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Determining a Child's Eligibility

For the purpose of determining eligibility, "child" includes your:

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Company-recognized Domestic Partner as defined by the Plan As of January 1, 2017, the Plan will no longer cover Domestic Partners and their children.
- Stepchild
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" in the Additional Health Benefit Rules section).
- Special Dependent, if you meet all of the following requirements:
  - You must have legal custody and legal guardianship of the child.
  - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support
  - You must submit a Special Dependent Statement**,** available under Health & Welfare forms on the benefits page on my.envoyair.com**,** to the Benefits Service Center and the Benefits Service Center must approve the form. (Complete and return the form to the Benefits Service Center, along with copies of the official court documents awarding you custodianship or guardianship of the child.) You must receive confirmation from the Benefits Service Center notifying you of its determination.

- The Benefits Service Center will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 30 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by the Benefits Service Center. If you submit the request after the 30-day time frame, the child will not be added to your coverage.

Parents and Grandchildren

Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian). However, you may be eligible for reimbursement of their eligible expenses under the Health Care and Dependent Day Care Flexible Spending Accounts (see the *Health Care FSA* and the *Dependent Day Care FSA* sections), if you claim your parent or grandchild as a dependent on your federal income tax return.

Dependents of Deceased Employees

If you have elected medical coverage for your Domestic Partner, Spouse and Children and you die as an active employee, your dependents' medical coverage may continue for 90 days at no contribution cost by electing COBRA. Your covered dependents are also eligible to continue medical coverage and certain other benefit options for up to 36 months under COBRA (see "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section) at the full COBRA rate. This 90 days of coverage is part of the 36 months of COBRA coverage.

Your covered dependents can elect to continue Dental Benefits and certain other benefits (if applicable) under COBRA at the full COBRA rate, if they had Dental Benefits at the time of your death. To continue dental coverage, your dependents must pay contributions effective from the day of your death.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Proof of Dependent Eligibility

As a reminder, the Company and its Affiliates reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct, available on my.envoyair.com, and may result in termination of employment, benefit or plan coverage termination, and recovery of any overpaid benefits.

Whether you:

- enroll dependents when you are first eligible to enroll in benefits, or
- enroll new dependents at annual enrollments, or

- enroll new dependents as the result of a Life Event,

You must submit to the Benefits Service Center proof of the dependents' eligibility within 30 days of the date you request their enrollment. Proof that dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage certificates, etc. The proof of eligibility requirements are listed on my.envoyair.com, under Benefits, in the Resources site, or you may contact the Benefits Service Center for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section).

IMPORTANT: Coverage for your dependents will not be in place until you have timely requested their enrollment and provided satisfactory proof of eligibility. Coverage will be retroactive to the date of the event (e.g., marriage, birth, new hire date) and your paycheck is adjusted as necessary.

Determining a Spouse, Common Law Spouse, or Domestic Partner's Eligibility

Throughout this Guide, the term "spouse" is used to refer to your legally married spouse (of the same or opposite sex spouse), as well as your eligible common law spouse or Company-recognized Domestic Partner unless Company-recognized Domestic Partners are addressed separately. Under current laws, a Company-recognized Domestic Partner's health care expenses may not be reimbursed from your Health Care Flexible Spending Account and expenses for the children of your Domestic Partner may not be reimbursed from your Dependent Day Care Flexible Spending Account, unless the Domestic Partner is your tax dependent.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Please see the definitions below of spouse and common law spouse to understand eligibility requirements for spouse coverage under the Plan.

- **Spouse.** Your Spouse means the lawful wife or husband of an employee (of the same or opposite sex), provided such marriage has been licensed by a governmental authority. If you and your Spouse were married outside the United States or its territories and protectorates, your marriage must be legally documented via marriage certificate from the state or country government that permitted and certified your marriage. You and your spouse must not be married to, or have a Domestic Partner, common law, or other spouse-like relationship with any person(s) at the same time you are married to each other.
- **Common Law Spouse.** Common law spouses are eligible for enrollment in Plan benefits only if your common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage. To enroll your common law spouse for benefits, you must complete and return a Common-Law Marriage Recognition Request and provide proof of common law marriage, as specified on the form. You and your common law spouse must not be married to, or have a Domestic Partner (DP), common law, other spouse-like relationship with any other person(s) at the same time you are in a common

law marriage to each other. Although criteria vary by state, the following guidelines usually apply:

- The couple cohabitates for a specified period of time established by the state.
- The persons recognize each other as husband and wife.
- The persons hold each other out publicly as husband and wife.

- **Domestic Partners.** Company-recognized Domestic Partners are defined as two people in a spouse-like relationship who meet all of the following criteria:
  - Are the same gender
  - Reside together in the same permanent residence and have lived in a spouse-like relationship for at least six consecutive months
  - Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
  - Are not legally married to, or the common law spouse or Company-recognized Domestic Partner of any other person
  - Submit a complete and valid Declaration of a Domestic Partnership from the Company-recognized Domestic Partner Enrollment Kit.

Company-recognized Domestic Partners and their eligible dependent children ARE eligible to be covered under the following benefits:

- Out-of-Area, PPO 750, PPO 1500 and PPO 2500 Options
- Health Maintenance Organizations
- Dental Benefit
- Vision Insurance Benefit
- Accident Insurance Benefit
- Spouse Life Insurance Benefit

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Note on Health Care Flexible Spending Accounts: Under current laws, a Company-recognized Domestic Partner's health care expenses may not be reimbursed from your Health Care Flexible Spending Account and child care expenses for your Domestic Partner children may not be reimbursed from your Dependent Care Account, unless the Domestic Partner is your tax dependent.

Note on Tax Dependents: Unless your Domestic Partner and your Domestic Partner's Children are your tax dependents, the Company will be required to report the value of any medical coverage provided to them as additional wages on your Form W-2. Please see the Domestic Partner Enrollment Kit for further details. After reviewing the Company-recognized Domestic Partner Kit, if

you need additional information regarding benefits and privileges available to Company-recognized Domestic Partners, please contact the Benefits Service Center at 1-844-843-6869.

Special Rules that Apply to Employees Married to Other Employees

Employees Married to Other Employees

When two employees are married to each other, they are referred to as "Married Employees" for this section. Married employees have the option of being covered as: (1) two single employees, each with their own employee coverage, or (2) under one employee's Medical, Dental and/or Vision benefits as an employee and a dependent. Married employees may elect to be covered under one employee's benefits during Annual Enrollment or at the time of a qualified Life Event (if the qualified Life Event allows such a change). If one employee decides to be covered under the other employee as a dependent, the employee covered as a dependent spouse, will not receive the company provided AD&D and Basic Life insurance, which is automatically provided to employees enrolled as employees in medical coverage.

Change in spouse's employment: If one spouse ends his or her employment with the Company, the spouse who changes his or her employment is eligible for coverage as a dependent (if he or she waives coverage under the subsidiary's health benefits). However if an employee is discharged for gross misconduct not related to any existing health condition for which treatment was provided for under the Plans, benefits or medical benefit options or dental benefit, he or she cannot be covered as a dependent of the active employee.

Spouse not eligible for full benefits: During the one-month waiting period required to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits. If your spouse is working as a part-time employee, he or she may waive medical and dental coverage and be covered as a dependent under your coverage.

Spouse on leave of absence: For leaves such as a personal leave of absence, when Company-provided benefits terminate, a spouse on a leave of absence may continue to purchase coverage as an employee on leave or elect to be covered as the dependent of the actively working spouse, but not both.

The actively working spouse's health coverage determines the health benefit coverage for all dependents. Because a leave of absence is a Life Event (see *Life Events*), the actively working spouse may make changes to his or her other coverages.

The actively working spouse may elect to:

- Add the spouse on leave as a dependent
- Cover only eligible dependent children
- Cover both the spouse and children.

If an employee elects to be covered as a dependent during a leave of absence, the following conditions apply:

- Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave

- Proof of good health may be required to re-enroll or increase optional coverages upon the employee's return to work.

Company-provided coverage (where the Company pays its share of the cost and the employee on leave pays his/her share) may continue for a period of time for employees on leave of absence, dependent upon receipt of your payment for the first twelve months of leave of absence for employees on an unpaid sick, unpaid Injury-on-Duty, unpaid FMLA or unpaid maternity leaves.

Other Information

Eligible dependent children*:* If both spouses are covered under the Group Health and Welfare Benefits Plan, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise. Contact the Benefits Service Center at 844-843-6869 to change this requirement. Children cannot be covered under both parents' health benefits. See "Dependent Eligibility

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Contributions: If both you and your spouse are covered independently under the Group Health and Welfare Benefits Plan and select exactly the same medical or dental option at the same cost, your contributions will be adjusted to ensure you pay approximately the same for your total family coverage as you would if your spouse worked elsewhere. The savings will be divided equally and applied to both your paychecks.

Family deductibles: Family deductibles (described under "Key Features of the Medical Options" in the *Medical* section) apply if both employees choose the same medical option. If the parents choose different options, the family deductible applies to the employee covering the children and the individual deductible applies separately to the other parent.

HMO participation*:* If you and your spouse enroll in the same HMO, the entire family unit is covered under the male employee's name because of HMO administrative procedures. If the male spouse takes a Leave of Absence (LOA), coverage for the family unit transfers to the female spouse for the duration of the leave. Company-recognized Domestic Partners are eligible for HMO coverage.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

Life insurance: Both employees are eligible to elect life insurance covering their spouse regardless of any other life insurance coverage the spouse has elected as an employee. Both parents may elect Child Term Life Insurance (see "Spouse and Child Term Life Insurance Benefits" in the *Life Insurance* section) for eligible dependent children.

Accident coverage: Each of you may enroll for yourself. You cannot be covered as an employee and a dependent; therefore, only the parent who elects medical coverage for the dependent children may elect family accident coverage, and the spouse must waive coverage. If your spouse works for an American Airlines Group subsidiary that does not offer accident coverage, you may elect Voluntary Personal Accident Insurance Benefits (see "AD&D and VPAI Benefits" in the *Accident Insurance* section) for him or her.

Flexible Spending Accounts: Deposits to the Health Care and Dependent Day Care Flexible Spending Accounts (see the *Health Care FSA* and the *Dependent Day Care FSA* sections) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one

spouse is making deposits to the account, claims must be submitted under that person's Social Security number. If you both make deposits, you may only contribute the maximum amount the law permits for a couple filing a joint tax return. You may not file claims for expenses incurred by a Company-recognized Domestic Partner or his or her dependents under your Flexible Spending Accounts according to federal law.

General Enrollment

New Employee Enrollment

As an Envoy or Affiliate employee, in order to receive coverage when first eligible, you must complete an online enrollment or call the Benefits Service Center within 30 days of your start date. If you do not complete the enrollment process, you will not be enrolled in any benefits, and your next opportunity to enroll will be during the annual open enrollment period for the following year unless you experience a Life Event that would enable you to make such a change. The Benefits Service Center will be updated annually with benefit options and new rates for the upcoming year. You will receive enrollment information shortly after you begin working. Upon completing one month of Company service, you will be eligible to receive Company subsidized medical, dental, basic life, and basic accidental and dismemberment insurance. You may elect coverage for yourself and your eligible dependents (see "Dependent Eligibility" in the *General Eligibility* section) and have a ONE-TIME opportunity to enroll in the following coverage without having to provide proof of good health:

- Long Term Disability Insurance Benefit (LTD)
- Optional Short-Term Disability Insurance (OSTD) Benefit
- Voluntary Term Life Insurance Benefit at one times your annual salary

You may choose Voluntary Term Life Insurance equal to one times your salary without proof of good health. You may choose a higher level of Voluntary Term Life Insurance with proof of good health. During future annual enrollments, you may only increase your life insurance one level each annual enrollment with proof of good health. Proof of good health is required if you wish to enroll in the above coverage after you first become eligible or you choose to increase life insurance coverage levels at a later date. You must submit a completed Personal Health Application form to The Hartford to add or increase Life Insurance coverage, or to elect OSTD or LTD at a later date within 30 days after your enrollment. If your Personal Health Application form is not postmarked within 30 days after the close of annual enrollment, or if you do not complete and submit the online Personal Health Application within 30 days of your election, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

Employees have the opportunity to select benefits tailored to individual needs and preferences. The Benefits Service Center on the benefits page of my.envoyair.com reflects the current benefits coverage available to you and the rates for the coverage.

Current Employees

Annual Enrollment

Each fall, eligible employees have the opportunity to select benefits for the following Plan Year — January 1 through December 31. During the annual enrollment period, you can enroll online for coverage, make changes to your prior elections, or continue your previous elections at the applicable new rates. (New rates will be available in your Benefits Service Center on my.envoyair.com.) With the exception of specific Life Events, annual enrollment is the only time you can change your coverage selections.

Once Annual Enrollment ends, your benefit elections for the upcoming Plan Year are recorded and "locked in", and you are not allowed to make changes to these elections until the following year unless you experience a Life Event that would enable you to make such changes. If proof of good health is required, the effective date for coverage, if approved, may be delayed to allow for review of your Personal Health Application from The Hartford (e.g., to add or increase Life Insurance coverage).

Some benefits and plans require proof of good health, if you elect these benefits or plans at any time after you first became eligible to enroll. During annual enrollment, if you want to:

- increase the amount of your employee or spouse term life insurance benefit;
- enroll in Optional Short Term Disability Insurance, or
- enroll in Long Term Disability Insurance

You must complete a Personal Health Application form from The Hartford within 30 days after the close of annual enrollment. For example, if during annual enrollment for the 2016 benefit year you elect to increase the amount of your employee term life insurance for 2016, you must submit your Personal Health Application form to The Hartford no later than 30 days after the annual enrollment period ends. If your statement is submitted more than 30 days after the close of annual enrollment, your application for this coverage will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for the coverage.

Please Be Aware of These Important Points:

The annual enrollment period occurs each fall.

- If you do not enroll for benefits during the annual enrollment period, you will be deemed to have consented to automatically default to your current selections (if available) for the following year, at the applicable rates for the following year and your payroll deductions will be adjusted accordingly. Please note that Health Care FSA and Dependent Day Care FSA require you to enter an election amount each year and do not roll over.
- If one of your current selections is no longer available, you will default to the applicable benefit or plan as listed in the table under "Current Employees
-
- Annual **Enrollment**
-

Annual Enrollment

- After annual enrollment, you will only be able to make changes to your elections if you experience a qualifying Life Event. (see the *Life Events* section).
- If you are adding new dependents to your benefits during the annual enrollment period, keep in mind that you must submit to the Benefits Service Center proof that these dependents qualify as your eligible dependents within 30 days of the date you enroll them. Proof that the dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage certificates, federal tax returns, etc. The proof of eligibility requirements are listed on my.envoyair.com, under Benefits, in the Resources site, or you may

contact the Benefits Service Center for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section).

Note: Flexible Spending Account elections do not automatically carry over to the following year. If you do not enroll and enter an amount, you will not have FSA dollars in the following benefit plan year.

Newly eligible employees who do not complete the enrollment process will not be enrolled in any benefits. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

As a new employee, you can enroll for benefits when you are first eligible during your "enrollment window", and each year, during annual enrollment, you can enroll for benefits that will be effective the following year. The Benefits Service Center will be updated annually with benefit options and new rates for the upcoming year.

Default Medical Coverage for Current Employees

This page indicates the default benefits that may be assigned and explains when default benefits apply.

During annual enrollment, if you do not make selections for the upcoming benefit year, you will default to the same benefits and plans (at the applicable new rates) as you are enrolled in for the current year with the following exceptions:

Benefit	Default	Comments
Medical Benefit Option	PPO 750, PPO 1500, PPO 2500 and Triple-S HMO	If your current medical benefit option is not available in your location, you and your eligible dependents will be enrolled in the Out-of-Area option. Employees with a Puerto Rico address will default to the PPO 750 option, if the current plan is no longer available. **Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.**
Flexible Spending Account Benefits (Health Care FSA, Dependent Day Care FSA)	No coverage	Your FSA accounts will default to $0.00 unless you enter an amount.

Waiving Coverage

You may choose to waive coverage if you do not want to participate in the Plan. Please keep in mind that your dependents will not receive coverage unless you are covered. If you waive coverage, you

can enroll in coverage later in the year only if you experience a qualifying Life Event such as marriage, divorce or the birth or adoption of a child.

How to Enroll

Follow these steps to enroll before your enrollment deadline:

Step 1: Visit the Enrollment Center on my.envoyair.com

- Look over the information contained in the Benefits Service Center on my.envoyair.com. The Benefits Service Center displays your benefit options for the remainder of the year and the per pay period costs for each option.
- Verify that the personal information shown is correct.

Step 2: Review your dependents

- You may add your spouse and any eligible dependent children during enrollment.
- After you have added your dependents, if any, it is necessary to decide whether or not you wish to cover each dependent under your Group Medical Benefit Option before continuing with your enrollment for other benefits.
- Within 30 days of your enrolling your dependents for benefits, you must submit to the Benefits Service Center proof that these dependents qualify as your eligible dependents. Proof that the dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage certificates, etc., as described in the Proof of Eligibility Requirements.

Step 3: Enroll

- You can enroll online on my.envoyair.com any time before the enrollment deadline. Or if you prefer, you can enroll by calling the Benefits Service Center at 1-844-843-6869.
- Be sure to enroll within 30 days of your hire date. Newly eligible employees that do not complete the enrollment process will not be enrolled in any benefits.
- You will not have another opportunity to enroll until the next annual enrollment period— or unless you experience a qualifying Life Event (see *Life Events*).

Coverage Levels

You may choose from the following levels of coverage for medical, dental and vision:

- Employee
- Employee + One
- Employee + Two or more.

When Coverage Begins

If you enroll by the enrollment deadline, your selected coverage is retroactive to the date you are first eligible for benefits and your paycheck is adjusted as necessary. If you select an HMO and need medical care during this interim period, you must receive treatment from a network provider to receive network coverage. If not, you will have no coverage if enrolled in an HMO.

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

Paying for Coverage

Each year the Company reviews the benefit options offered to employees and the cost of each plan. Based on your employment status and the number of family members enrolled in your coverage, the Company pays a certain amount towards the cost of your benefits. Once you have completed one month of Company service, the Company pays a portion of the cost of your medical and dental coverage; you pay the remaining amount of the actual cost for providing these benefits. Your contributions are fixed premium obligations and you will not be entitled to any reduction or refund of your contributions (including, without limitation, applicable deductibles or co-payments) in the event that the claims experience of the Plan is more favorable than projected or the Plan receives any discount, refund, rebate, settlement or damages pursuant to an agreement with or settlement or judgment with or from an insurer, any medical provider or other organization or individual.

Company-Provided Benefits

All eligible employees are provided with basic benefits protection. These benefits include:

- **Medical Benefits.** You can choose from PPO 750, PPO 1500, PPO 2500, Out-of-Area or an HMO option (if available in your area). Your contributions fund a portion of the cost with the Company covering a portion of the cost.

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

- **Dental Benefit.** You contribute a portion of the contribution cost.
- **Basic Life Insurance** coverage based on 1 times your annual salary for benefits (if enrolled in medical)
- **Accidental Death and Dismemberment Insurance** of 1 times your annual salary (if enrolled in medical).
- **Vision Discount Program:** All employees who elect medical coverage will be offered this program(See *Vision Benefits*).
-

  Note that the Vision Discount Program will no longer be offered on or after January 1, 2017.

Employee-Paid Benefits

In addition to these Company-provided benefits, you can select from a number of optional benefits for which you pay the full cost. These include:

- Vision Insurance
- Voluntary Term Life Insurance
- Voluntary Personal Accident Insurance
- Optional Short Term Disability Insurance
- Long Term Disability Insurance

- A Health Care Flexible Spending Account
- A Dependent Day Care Flexible Spending Account
- Critical Illness Insurance
- Legal Services

You pay the same amount for benefits per pay period. Depending on your pay cycle, here is how payroll deductions work. (The amount may vary by a few cents due to rounding.) If you are paid:

- **Semi-monthly:** You always receive two paychecks per month, so the same amount is deducted from each paycheck.
- **Bi-weekly:** You generally receive two paychecks per month, and the same amount is deducted from each paycheck. In months with three pay periods, all three checks will have the same benefit deductions as your other paychecks.
- **Weekly:** You generally receive four paychecks per month, and the same amount is deducted from each paycheck. In months with five pay periods, all five paychecks of the month will have the same benefit deductions.

The amount deducted from your paycheck is your contribution to the cost of coverage. (The amount may vary by a few cents due to rounding.)

Taxation of Benefits

You pay for most benefits on a pre-tax basis, which means the cost of your benefits is deducted from your pay before taxes are calculated. Tax withholding is calculated only on the remaining amount. Therefore, your contributions for pre-tax benefits actually reduce your taxable income, and the amount of taxes withheld from your pay is also lower. However, a few benefits must be paid on an after-tax basis.

The following table summarizes options available to eligible employees under the Plan. The second column shows whether you pay for the benefit pre-tax. The third column indicates whether you may waive coverage (choose no coverage) for this benefit option.

Type of Benefits	Before-Tax?	May Waive?
Medical Benefit Options (for employee and tax dependents) ▪ PPO 750 Option ▪ PPO 1500 Option ▪ PPO 2500 Option ▪ Out of Area Option ▪ Health Maintenance Organizations Option (HMOs)	Yes	Yes*
Medical Benefit Options (for non- tax dependents) ▪ PPO 750 Option ▪ PPO 1500 Option ▪ PPO 2500 Option ▪ Out of Area Option ***Health Maintenance Organizations Option (HMOs) Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.***	No	Yes*

Type of Benefits	Before-Tax?	May Waive?
Vision Insurance Benefit	Yes	Yes
Voluntary Term Life Insurance Benefit (below $50,000)	Yes	Yes**
Voluntary Personal Accident Insurance Benefit	No	Yes
Spouse Term Life Insurance Benefit	No	Yes**
Child Term Life Insurance Benefit	No	Yes
Optional Short Term Disability Insurance Benefit	No	Yes**
Long Term Disability Insurance Benefit	No	Yes**
Health Care Flexible Spending Account Benefit	Yes	Yes***
Dependent Day Care Flexible Spending Account Benefit	Yes	Yes
Critical Illness	No	Yes*
Dental Benefit Option	Yes	Yes*
Legal Services	No	Yes

* Your dependents cannot have coverage if you are not covered.

** Requires proof of good health any time you increase your level of coverage or if you waive coverage and later decide to elect it.

*** During the year, if you experience a qualifying Life Event, you may start or increase contributions to a Health Care Flexible Spending Account only if you are enrolling a dependent that was not previously covered.

When Coverage Ends

Coverage for you and your dependents will automatically terminate on the earliest of:

- The date this Plan or benefit option terminates
- The last day for which your contribution has been paid
- The date you are no longer eligible for this coverage.
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan.
- The date you terminate employment or cancel coverage.
- The date your dependents no longer meet the eligibility requirements, as explained in the Dependent Eligibility Criteria.

Your spouse's coverage will automatically terminate on the earliest of:

- The date this plan or benefit option terminates
- The last day for which your spouse's contribution has been paid
- The date he or she is no longer your spouse
- The date you are no longer eligible for this plan or benefit option

- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the plan or benefit option.
- The date your surviving spouse remarries
- For a Company-recognized Domestic Partner, 90 days after your death (**this will no longer apply as of January 1, 2017**)

Expenses incurred after the date your coverage (or your spouse's coverage) terminates are not eligible for reimbursement under the plan or benefit option.

If you die as an active employee, your covered dependents continue to receive the same medical coverage they had before you died. COBRA Continuation Coverage continues for 90 days at no cost upon election of COBRA. At the end of 90 days, your eligible dependents are eligible to continue medical coverage for up to 36 months under COBRA at the full COBRA rate. The 90 days of coverage immediately following your death is included in the 36 months. Dental coverage is available for purchase through COBRA. All other coverage ends at the time of your death.

For information regarding benefits that can be continued through COBRA, see "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section.

Coverage Under the Plan While on a Family and Medical Leave, Unpaid Sick or Injury on Duty Leave, or a Military Leave

Under the federal Family and Medical Leave Act (the "Medical Leave Act") employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time, referred to in this guide as Family Medical Leave of Absence or FMLA.

If you are eligible, you can generally take up to 12 weeks of unpaid leave in a 12-month period for the reasons listed below:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition

Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

FMLA for Airline Flight Crewmembers

Special rules apply under FMLA for "airline flight crewmember," which is generally defined as employees that are on board an aircraft during launch or reentry (e.g., pilots and flight attendants). FMLA includes special rules applicable to airline flight crewmembers that outline (i) a separate method to calculate the number of hours of service for eligibility and (ii) a different number of days for which an eligible employee may take FMLA leave. An eligible airline flight crew employee is entitled to up to 72 days of FMLA leave during any 12-month period for the reasons listed below:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care

- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition

Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Unpaid Sick or Injury on Duty Leave of Absence

If you are receiving accrued sick pay, and during the first year (12 months) of an unpaid sick or Injury on Duty of absence (the "12-Month Period") you may be eligible to continue benefits for yourself and your eligible dependents for a period of time during such leave. After you have exhausted your accrued sick and after the 12-Month Period, your coverage ends, at that time you may elect continuation of coverage under COBRA. For information regarding benefits that can be continued through COBRA, see "Continuation of Coverage – COBRA Continuation" in the Additional Health Benefit Rules section.

The type of leave you take determines the cost of your benefits (i.e., whether you and the Company share the cost of benefits or whether you pay the full cost of benefits). In order to continue your benefits during a leave of absence, you must timely pay the required monthly contributions during your leave.

When you begin a leave of absence (when your payroll transaction record is changed to reflect that you're on a leave of absence),

- The Benefits Service Center sends you a letter acknowledging your leave, instructing you to call the Benefits Service Center at 1-844-843-6869, and requesting that you decide whether or not to continue your benefits while on your leave.
- Once you call and record your Life Event and benefit elections with the Benefits Service Center, you will receive a confirmation statement showing your choices, the monthly cost of benefits, covered dependents, etc.

- If you have not received a letter within 10 days of being placed on a leave, contact the Benefits Service Center immediately, so that you may continue your benefits while on leave.

During the initial period of an absence for a disability, while you are receiving accrued sick pay and during the 12-Month Period, the Company continues to pay its part toward the cost of your medical coverage for active employees, and you must pay your part of the cost, as well. You will receive a personalized Leave of Absence Worksheet when the Payroll Transaction Request (PTR) placing you on unpaid leave is processed. The worksheet lists your benefits options during the leave, costs for benefit coverage, and the election deadline. If you elect to continue your medical and dental benefit, this coverage ends at the end of the 12th month of your leave.

IMPORTANT: If you elect not to continue your benefits while on your leave, or if you fail to timely pay the required monthly contributions for coverage, your benefits will terminate for the duration of your leave of absence unless you are no longer eligible for coverage due to failure to satisfy the hours for Flight Attendants, Fleet Service Clerks, and Agents (e.g., if your leave crosses calendar years).

When you return to active status, you may reactivate most of your benefits; however, some benefits will require that you supply proof of good health in order to reactivate them (i.e., Long Term Disability Insurance, Optional Short Term Disability Insurance, and Voluntary Term Life Insurance).

With respect to your reactivating your Voluntary Term Life Insurance Benefit— if, for example, your prior-leave amount of life insurance was 4 times your annual salary, and you elected not to pay for your life insurance while you were on leave, once you've returned from your leave and provided proof of good health satisfactory to The Hartford, you are allowed to reactivate your life insurance ONLY to the first level of coverage (which is one times your annual salary).

Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of COBRA Continuation of Coverage available to you and your eligible dependents is the lesser of 24 months (for elections of coverage on or after December 10, 2004) or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any period of COBRA Continuation of Coverage for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days. The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Employee Policy Guide

Family Medical Leave of Absence (FMLA) or Military Leave

If your leave is an FMLA or military leave, special rules govern your rights to continue or resume your benefits, which are based on federal law.

During the first year (12 months) of an unpaid sick or unpaid injury on duty leave of absence, you may keep the same benefits you had while actively working. You are responsible for timely paying your share of the cost for coverage during your leave. After this 12-Month Period, your coverage ends, at that time you may elect continuation of coverage under COBRA. However, if you terminate your benefits during the 12-Month Period, when you return to active status you may reactivate your Medical, Dental and/or Vision benefits if you continue to satisfy the hours requirements applicable to flight, crew, and/or agents.

For a detailed description of each leave of absence, consult with your supervisor.

Life Events and Special Enrollment Rights: Making Changes During the Year

After annual enrollment is completed each year, you may only change your elections if you experience a HIPAA Special Enrollment Event, Special Enrollment for Medicaid and CHIP, and Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience, as shown in the "Table of Life Events and Permitted Benefit Changes" and on the Life Events landing page on my.envoyair.com.

<u>HIPAA Special Enrollment Rights – Medical Benefit Option Only</u>

If you or your dependents declined coverage under the Medical Benefits Option because you or they have medical coverage elsewhere and one of the following events occurs, you have 30 days from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option. Effective January 1, 2017, you will have 30 days from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option.

- You and/or your dependents (including your Company-recognized Domestic Partner and the children of your Company-recognized Domestic Partner*) lose the other medical coverage because:
    - eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
    - the employer contributions to the other coverage have stopped.
    - the other coverage was COBRA and the maximum COBRA coverage period ends.
    - you and/or your dependents (including your Company-recognized Domestic Partner and the children of your Company-recognized Domestic Partner*) exhaust a lifetime maximum in another employer's health plan or in other health insurance coverage.
    - Your employer and/or your dependent's, including your Company-recognized Domestic Partner's, employer cease to offer health benefits to the class of employees through which you (or one of your dependents) have coverage.
    - You and/or one of your dependents (including your Company-recognized Domestic Partner and the children of your Company-recognized Domestic Partner*) were enrolled under an HMO or other group or individual plan or coverage arrangement that will no longer cover you and/or one of your dependents) because you and/or your dependent no longer reside, live, or work in its service area

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).

- You have a new dependent as a result of your marriage, declaration of a Company-recognized Domestic Partner*, your child's birth, adoption, or placement for adoption with you.

As an employee, you may enroll yourself and your new spouse and any dependents within 30 days of your marriage and a new child within 30 days of his or her birth, adoption or placement for adoption. If you miss the 30-day deadline, the enrollment will not be processed. You will have to wait until the next annual enrollment period to enroll your dependent. In addition, if you are not enrolled in the employee benefits as an employee, you also must enroll in the employee benefits when you enroll any of these dependents. And, if your spouse is not enrolled in the employee benefits, you may enroll yourself and/or him or her in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. Coverage is retroactive to the date of marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact the Benefits Service Center (see "Contact Information" in the *Reference Information* section).

- If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit proof that these dependents qualify as your eligible dependents. Proof that the dependents you enroll qualify as your dependents include (but are not limited to) official government-issued birth certificates, adoption papers, marriage certificates, etc. The proof of eligibility requirements are listed on my.envoyair.com, on the Benefits page, or you may contact the Benefits Service Center for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section). Please note you will be responsible for retroactive contribution to coverage from the date of your life event.

*** Please note as of January 1, 2017, the Plan will no longer provide coverage for Domestic Partners.**

Special Enrollment Rights Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP)

An employee and/or eligible dependent, including a Company-recognized Domestic Partner and the children of a Company-recognized Domestic Partner, may enroll in the Plan if he or she is no longer eligible for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act, if the employee and/or eligible Dependent requests coverage under the Plan within 30 days after the date of termination from this coverage. Such coverage shall be effective on the date of the event.

In addition, an employee and/or eligible dependent, including a Company-recognized Domestic Partner and the children of a Company-recognized Domestic Partner, may enroll in the Plan if he or she becomes eligible for assistance under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act, where such assistance will be provided through the Plan, if the employee and/or eligible Dependent requests coverage under the Program within 30 days of the date that he or she is determined to be eligible for assistance. Such coverage shall be effective on the date of the event.

Keep in mind that if you are adding dependent(s) to your benefits during this special enrollment period, you must submit proof that these dependents qualify as your eligible dependents, and proof of loss of Medicaid or CHIP coverage, or proof of eligibility for the state premium assistance (under Medicaid or CHIP). Proof that the dependents you enroll qualify as your eligible dependents includes

(but is not limited to) official government-issued birth certificates, adoption papers, etc., as described in the Proof of Eligibility Requirements.

Life Event

You also may change certain elections mid-year if you experience a Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience.

You must register the Life Event within 30 days of the event with the Benefits Service Center. You must submit proof of the dependent's eligibility to the Benefits Service Center within 31 days of the date the documentation is requested. Proof of eligibility cannot be submitted until you receive the request from the Benefits Service Center. **If you miss the 30 day deadline, your Life Event change will not be processed.** You will have to wait until the next Annual Enrollment Period to make changes to your benefits. Effective January 1, 2017, you will have **30 days** from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option.

When you experience a qualifying Life Event, keep these important thoughts in mind:

- Most Life Events can be processed by calling the Benefits Service Center directly at 1-844-843-6869.
- If you process your Life Event within 30 days of the event, your changes are retroactive to the date the Life Event occurred (or the date proof of good health is approved, as applicable).

However, if your dependent(s) lose eligibility under the Plan, you must contact the Benefits Service Center to remove the ineligible dependent(s) from coverage – even if you have missed the 30-day deadline. If you contact the Benefits Service Center after the 30-day deadline you will be able to remove your dependent(s) from coverage, but the effective date of the removal will be the date you notified us, and your resulting contribution rate changes, if any, will be effective as of the date you notified the Benefits Service Center. You will not receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified the Benefits Service Center of their ineligibility. Keep in mind that if you do not notify the Benefits Service Center of your dependent(s)' eligibility within the 30-day timeframe, the dependent(s) will lose their right to continue coverage under COBRA, so it is important that you are timely in registering your dependent(s)' removal from coverage within the 30-day timeframe.

- The Company and its Affiliates reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in termination of employment and termination of benefits coverage.

If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit proof that these dependents qualify as your eligible dependents within 30 days of the date you enroll them. Proof that the dependents you enroll qualify as your dependents include (but are not limited to) official government-issued birth certificates, adoption papers, marriage certificates, etc., as described in the Proof of Eligibility Requirements.

- Any change in your cost for coverage applies on the date the change is effective. Catch-up contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.

- You cannot enroll your dependents for coverage if you are not covered.
- You may start or increase a Health Care Flexible Spending Account only if you have enrolled a dependent that was not previously covered. Starting or increasing either Life, Accident, or Disability insurance may require proof of good health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance. When you add Life or Accident Insurance, you must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations, and you can make beneficiary changes on the Benefits Service Center. Once you complete and submit the online **Beneficiary Designation Form**, it supersedes all previous designations.
- If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment Insurance that will be paid is your "default coverage." If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.
- You or your spouse may only increase your Life Insurance coverage by one level per year, with proof of good health.
- If you elect to enroll in any coverage requiring proof of good health, you must submit (postmarked) a completed, dated, and signed Personal Health Application from The Hartford within 30 days after your enrollment/election date. If your statement of health is not postmarked within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.
- If you plan to cover your Company-recognized Domestic Partner under your Life Insurance, you must submit The Hartford Affidavit of Company-recognized Domestic Partnership. This form is part of the Company-recognized Domestic Partner Enrollment Kit. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).**

See also "Special Life Event Considerations" for other information regarding Life Events that may trigger allowable changes in coverage.

Table of Life Events and Permitted Benefit Changes

This table describes the changes you may make when certain life events occur.

If…	Then, You Can…
You become eligible for Company-provided benefits	Enroll online through the Benefits Service Center.
You get married or declare a Company-recognized Domestic Partner (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children)).**	▪ **Medical Benefits Options:** Add coverage for your spouse and eligible dependents; stop coverage for a dependent or yourself. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum will not carry over to your new Medical Benefit Option**. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage, however this coverage applies to the employee only. ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your spouse and/or child, or increase or decrease existing employee coverage. ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You divorce or legally separate, ***Your Company-recognized Domestic Partner relationship ends, or*** ***You obtain a protective order*** (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children)).**	▪ **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for your spouse. Add coverage for yourself and/or your eligible dependents (dependent coverage may be subject to QMCSO—see "Qualified Medical Child Support Order" in the *Additional Health Benefit Rules* section). You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your spouse and/or child, or increase or decrease existing employee coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for yourself; stop coverage for spouse or child; increase or decrease existing employee coverage ▪ **Flexible Spending Accounts Benefits:** Start/stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You or your spouse becomes pregnant	▪ This does not permit you to make any changes in your benefit elections until the baby is born

If…	Then, You Can…
You or your spouse gives birth or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household	▪ **Medical and Dental Options and Vision Insurance Benefit:** Start/add coverage for the dependent(s) and yourself, and/or your spouse. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum will not carry over to your new Medical Benefit Option**. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your child, increase or decrease existing coverage for you with proof of good health ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
Your covered dependent no longer meets the Plan's eligibility requirement	▪ **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for dependent. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your dependent; increase or decrease existing coverage for you with proof of good health ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
Your dependent child attains age 13 or he no longer requires dependent day care ***OR*** ***Your elderly parent no longer requires dependent day care***	▪ **Dependent Day Care Flexible Spending Account:** Stop or reduce Dependent Day Care Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.

If…	Then, You Can…
Your spouse, Company-recognized Domestic Partner or dependent dies (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children)).**	▪ **Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent. You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible dependent; increase or decrease existing coverage for you with proof of good health. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent or start or stop coverage for yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
Change in spouse's/Company-recognized Domestic Partner's employment or other health coverage ***OR*** ***spouse's/Company-recognized Domestic Partner's employer no longer contributes toward health coverage*** ***OR*** ***Your spouse's/Company-recognized Domestic Partner's employer no longer covers employees in your spouse's position*** (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).**	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse, your eligible dependent or yourself; stop coverage for your eligible spouse, eligible dependent or yourself. You cannot change benefit plans at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible spouse/Company-recognized Domestic Partner or eligible dependent in the applicable benefit option. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You and/or your eligible dependent(s) declined Company medical coverage because you or they had coverage elsewhere (external to Company), and any of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your eligible dependents in a Medical Benefits Option: ▪ Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) ▪ Employer contributions for the other coverage stopped ▪ Other coverage was COBRA and the maximum COBRA coverage period ended ▪ Exhaustion of the other coverage's lifetime maximum benefit ▪ Other employer-sponsored coverage is no longer offered ▪ Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible dependents no longer reside, live, or work in its service area ▪ You have a new dependent via your marriage, your child's birth/adoption/placement	You have 30 days from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you, unless it is a HIPAA special enrollment event (see "Life Events and Special Enrollment Events"). Effective as of January 1, 2017, you will have **30 days** from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you. **This event allows you to add medical coverage only.**

If…	Then, You Can…
for adoption with you **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).**	

If…	Then, You Can…
You or your dependent exhausts a lifetime limit in another medical plan ***You or your dependents were enrolled in an HMO or another arrangement that will no longer cover you due to your failure to live, work or reside in the arrangement's service area***	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

If…	Then, You Can…
You move to a new home address: ▪ Update your address online at my.envoyair.com ▪ Submit a revised W-4 form for payroll tax purposes. The form is available online at my.envoyair.com ▪ Contact other organizations such as the American Airlines Credit Union and C. R. Smith Museum directly to update your contact information ▪ Provide your new address and current emergency contact numbers to your supervisor, as well	▪ **Medical Benefits Option:** May select from medical options available in new location if you moved out of the service area to any area with different options available. Contact the Benefits Service Center for more information. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent; increase or decrease existing coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You become disabled	▪ **Notify:** Your supervisor and call The Hartford to initiate a disability claim (if enrolled) ▪ **Complete and submit:** Your claim for disability benefits
You take a leave of absence	▪ **You will receive:** A personalized Leave of Absence Worksheet from the Benefits Service Center when the Payroll Transaction Request (PTR) placing you on unpaid leave is processed. The worksheet lists your options during the leave, cost for benefits coverage, and the election deadline. ▪ **Your cost depends on:** The type of leave you are taking

If…	Then, You Can…
You return from an unpaid leave of absence	▪ **Medical and Dental Options and Vision Insurance Benefit:** Resume coverage. You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage; increase or decrease existing employee coverage. ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You change from part-time to full-time or full-time to part-time*	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent, or increase or decrease existing coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You die	▪ **Continuation of Coverage:** Your dependents or Company-recognized Domestic Partner should contact your supervisor, who will coordinate with Envoy Survivor Support to assist with all survivor benefits and privileges. The Benefits Service Center will send information, including the election of Continuation of Coverage, if applicable.
Your Company-recognized Domestic Partner dies	▪ **Continuation of Coverage:** You will receive information about Continuation of Coverage through COBRA for the surviving children of your Company-recognized Domestic Partner, if you contact the Benefits Service Center as required below ▪ **Contact: The Benefits Service Center** within 30 days of your Company-recognized Domestic Partner's death to update your records and make the appropriate changes, if applicable, to your benefits coverage
You end your employment with the Company	▪ **Review:** When Coverage Ends within this Guide ▪ **Review:** The information you receive regarding Continuation of Coverage through COBRA ▪ **Contact: The Benefits Service Center** for information

If…	Then, You Can…
You transfer to another work group or subsidiary of American Airlines Group	**Contact:** Your supervisor, the Benefits Service Center, or the new subsidiary to determine benefits available to you and to make new benefit elections
Benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")	**Make changes to the applicable benefit coverage:** The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child	**Medical and Dental Options and Vision Insurance Benefit:** Start or add coverage for the dependent(s) and yourself. You cannot change benefit options at this time.
You, your spouse or your dependent enroll in Medicare or Medicaid	**Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for the applicable person. You cannot change benefit options at this time.
You or your dependent(s) lose Medicaid or CHIP coverage	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. If you are already enrolled in Medical, Dental, and Vision Options and are adding dependents, you cannot change medical or dental options at this time. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: No changes allowed at this time. ▪ **Legal Services Plan**: No changes allowed at this time.

If…	Then, You Can…
You or your dependent(s) become eligible for a state premium assistance program (under Medicaid or CHIP)	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum will not carry over to your new Medical Benefit Option**. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: No changes allowed at this time. ▪ **Legal Services Plan**: No changes allowed at this time.

***NOTE:** Eligibility and contribution amounts for medical & dental coverage for Agents and/or Fleet Service Clerks is determined by an analysis of hours worked during an annual look back period (as outlined in the Eligibility section of this guide). Once an eligibility and contribution status has been assigned through the look back analysis, it will remain unchanged for the entire Plan year, as long as you remain in the same workgroup.

Special Life Event Considerations

The following section explains special circumstances that may happen in your life and how these changes affect your benefits. You must take all of the steps described below for your special Life Event within 30 days of the date it occurs.

Special dependent: To cover a special dependent (foster child or child for whom you become the legal guardian), you must complete a Statement of Eligibility for Special Dependent and return it to the Benefits Service Center at the address on the form, along with copies of the official court documents awarding you custodianship or guardianship of the child, regardless of the medical option you select. For detailed criteria regarding coverage for a special dependent, see also "Dependent Eligibility" in the *General Eligibility* section.

Stepchild: You may add coverage for a stepchild if the child lives with you and you the employee, either jointly or individually, claim the stepchild as a dependent on your federal income tax return.

Birth or adoption of a child: To add a natural child to coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth. You should not wait to receive the baby's Social Security number or official birth certificate. These documents may take more than 30 days to arrive and prevent you from starting coverage effective on the baby's birth date.

To add an adopted child to your benefits coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective with the date the child is placed with you for adoption and is not retroactive to the child's date of birth.

Relocation: If you are enrolled in the PPO 750, PPO 1500 or PPO 2500 Option and you move to a location where PPO providers are not available, you must choose another medical option or you may waive coverage. If you are enrolled in an HMO and you move out of that plan's service area, you may choose another medical option or you may waive coverage. If you are enrolled in the Out-of-Area Option and move to an area where the PPO is available, you will no longer be eligible for the Out-of-Area Option. However, if you change to another medical option, your deductibles and out-of-pocket maximums do not transfer to the new option.

If you do not process your relocation Life Event within 30 days of your move, you will automatically be enrolled in another medical option and will receive a confirmation statement indicating your new coverage.

Benefit Coverage Affected by Life Events

Voluntary Term Life Insurance Benefit: You may only increase this coverage by one level per year with approved proof of good health.

Vision Insurance: You may add coverage for yourself and your eligible dependents if you experience a qualifying Life Event.

Optional Short Term Disability Insurance: If you elect coverage, your choice remains in effect for two calendar years. After this time, you have the option to continue or waive future coverage. However, you may add coverage if you have experienced a Life Event with approved proof of good health.

Flexible Spending Accounts Benefits: If you change the amount of your deposits during the year, claims from your Health Care Flexible Spending Account for eligible health care expenses incurred before the change are payable up to the original amount you elected to deposit. Claims for expenses incurred after the change are payable up to your newly elected deposit amount. You forfeit part of your balance when the deposits before your change are greater than your claims before the change and you reduce the amount you elect to deposit. Your Dependent Day Care Flexible Spending Account reimburses based on the deposits in your account at the time of the claim.

Remember, when you process a Life Event change, the change (if applicable) to your Flexible Spending Accounts is only valid for the remainder of the calendar year. If you process a Life Event change within the last 60 days of the year, there will not be time to process changes to your Flexible Spending Accounts for that year.

Benefit Coverage Not Affected by Life Events

The following benefits are not affected by Life Event changes, except as noted:

Medical Benefit Options: You may change Medical Benefit Options only if you relocate (see "Table of Life Events and Permitted Benefit Changes"). However, if you are enrolled in the PPO 750, PPO 1500, PPO 2500 or Out-of-Area Option, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in your new location.

Medical Benefits Overview

The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of illness or injury. Some options may not be offered in all locations. During enrollment periods (as a new employee when you are first eligible for benefits, during the annual enrollment period), or if you experience a qualifying Life Event, the Benefits Service Center will reflect the options that are available to you.

Generally, you may choose one of the Plan options listed below (collectively, the "Medical Benefits"). You may waive coverage; however, your dependents cannot have coverage if you are not covered. You will not be able to file claims under a medical option of the Plan if you waive coverage. You will not be able to enroll in coverage during the year unless you experience a qualified Life Event (see the "Table of Life Events and Permitted Benefit Changes" in the *Life Events* section).

- PPO 750 Option
- PPO 1500 Option
- PPO 2500 Option
- Out-of-Area Option
- Health Maintenance Organization (HMO) Option (for Puerto Rico employees). This option will be eliminated as of January 1, 2017. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).**
- As described in more detail below, some Medical Benefits are not offered in all locations. Employees residing in Puerto Rico will have the choice between an HMO and the PPO 750, PPO 1500, or PPO 2500 Options until December 31, 2016. All other employees will be eligible to participate in the PPO 750, PPO 1500, and PPO 2500 Options. Employees residing in St. Thomas and St. Croix, USVI, will have the choice between the Triple-S Salud HMO and the PPO 750, PPO 1500 and PPO 2500 until December 31, 2016. As of January 1, 2017, employees residing in St. Thomas and St. Croix, USVI will no longer have the Triple-S Salud HMO option. This determination is based on whether your alternate address zip code falls within a PPO service area. Each year an analysis is done to be sure that each PPO service area provides reasonable access to physicians, specialists, hospitals, and pharmacies for our members. If you live within a PPO service area you have a choice of the PPO 750 Option, the PPO 1500 Option or the PPO 2500 Option. If you do not live within a PPO service area you will be eligible for the Out-of-Area Option. Refer to *General Eligibility* for details regarding eligibility for benefits, dependent coverage, and employees married to other employee

Regardless of the medical coverage you select, you may take advantage of the Employee Assistance Program (EAP) offered by the Company (see *Employee Assistance Program* section for more information).

Out-of-Area Option

Only employees who do not have adequate access to PPO providers may enroll in the Out-of-Area Option.

The Out-of-Area Option allows you to use any qualified licensed physician. When you use a network provider under the Out of Area Option you receive a higher level of benefits. Network providers have agreed to charge discounted fees for medical services. Generally, you pay a percentage of the cost for each visit or service and the plan pays the rest. When you use network providers, you are not responsible for amounts billed in excess of the network rate for eligible expenses. When you use providers that are not part of the network, the Plan still pays the same coinsurance percentage but you will be responsible for any portion of the provider's billed fee that exceeds usual and prevailing fee limits.

Under the Out-of-Area Option you will receive the PPO in-network level of coverage. This benefit is offered to the Out-of-Area Option members because there are not a reasonable number of PPO providers within driving distance, as determined by your alternate home address zip code. If you live within a zip code that is covered by the PPO you will not be eligible for the Out-of-Area Option.

PPO 750, PPO 1500 and PPO 2500 Options

The PPO Options are offered in most locations, but if you live outside the network/claims administrator access area, you are not eligible for the PPO Options and may choose the Out of Area Option for medical coverage. You may access my.envoyair.com and list up to two addresses – a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many employees maintain more than one residence, you may list both addresses on my.envoyair.com; however, your alternate address determines which medical options are available to you. If you do not have an alternate address listed on my.envoyair.com, your network/claims administrator is based on your permanent address. The Enrollment section on my.envoyair.com will reflect which options are available to you. The PPO Options are administered by the same network/claims administrator, Blue Cross and Blue Shield of Texas.

You may decide whether to use network or out-of-network providers each time you need care under the PPO 750, PPO 1500 and PPO 2500 Options. Under the PPO 750 Option, when you use a network provider, you pay only a copayment or 20% coinsurance after deductible for most services provided by a network provider (with the exception for preventive care). Under the PPO 1500 and PPO 2500 Options, you pay 20% coinsurance after satisfaction of the deductible for services provided by a network provider. A deductible is required for any coinsurance-based services under the PPO 750, PPO 1500, and PPO 2500 Options.

If you go to a provider who is not part of the network, you are still covered for eligible, medically necessary services, but at a lower level of benefits, called the out-of-network benefit level. At the out-of-network benefit level, you pay a higher deductible and higher out-of-pocket amounts. For most out-of-network services, the plan pays 60% and you pay the remaining 40% after you satisfy the deductible. You will also be responsible for any amount exceeding the out-of-network reimbursement fee(s) which are calculated based upon Medicare allowable amounts. The amount you pay in excess of the out-of-network reimbursement rate will not apply to your out-of-pocket maximum. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the

remainder of the year. Please be sure to take this into consideration if you are considering using an out-of-network provider.

Health Maintenance Organizations (HMOs)

HMOs provide medical care through a network of physicians, hospitals and other medical service providers. You must use network providers to receive coverage under the HMO. Your expenses, including prescription drugs and mental health care, are covered according to the rules of the HMO you select.

Most HMOs require you to choose a primary care physician (PCP) to coordinate your medical care and to obtain a referral from your PCP before receiving care from a specialist.

HMOs are offered only in Puerto Rico and St. Thomas and St. Croix USVI. HMOs offered in your area appear as options in the Benefits Enrollment Center on my.envoyair.com during enrollment. When you enroll in an HMO, you will receive detailed information directly from that HMO.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).

Prescription Drug Coverage

If you are enrolled in the PPO 750, PPO 1500, PPO 2500 or Out-of-Area Options, you receive prescription drug coverage through the medical benefit. Coverage includes both retail pharmacy prescriptions (up to a 30-day supply) and mail order prescriptions (up to a 90-day supply). Prescription drug coverage is administered by Express Scripts.

If you participate in an HMO, contact the HMO for information about your prescription drug coverage.

How the Medical Options Work

Only employees who do not have adequate access to PPO providers will have the Out-of-Area Option. All other Medical Options provide different levels of benefits based on whether or not you use a network or out-of-network provider.

Under the PPO 1500, PPO 2500, and Out-of-Area Options, you are required to satisfy an annual deductible before the plan begins paying a percentage of the eligible, medically necessary expenses (with the exception of preventive care). All of the Medical Options allow you to use any qualified licensed physician. When you use a network provider, you are not responsible for the difference between the billed fee and the network rate. See "Special Provisions," below for information regarding physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services.

In a few rare cases, a U.S. employee may live outside all of the network areas and not have ready access to any of the provider networks. If you reside in a ZIP code which is outside of the preferred network providers' service areas, you will have the Out-of-Area Option available. You will not incur any penalty or reduction in benefits if you use a provider outside the preferred administrator's network, as long as your ZIP code is considered "out-of-area." However, when using out-of-network providers, you will be responsible for the difference between the providers' billed fees and the usual and prevailing fee limit. When possible, consider using an in-network provider so that you will not be

responsible for the difference between the billed fee and the network contract rate. This should reduce your out-of-pocket costs.

After meeting the annual deductible under the Out-of-Area Option and the in-network deductible under the PPO 750, PPO 1500 and PPO 2500 Options, the plan pays 80% of most eligible expenses for most medically necessary services. Your coinsurance is 20%. When using a non-network provider under the PPO 750, PPO 1500 and PPO 2500 Options, once you meet the out-of-network deductible, the plan pays 60% of most eligible expenses for most medically necessary services and your coinsurance is 40%. However, any time you use an out-of-network provider, you will be responsible for the difference between billed charges and the out-of-network reimbursement rate. The amount you pay in excess of the out-of-network reimbursement rate will not apply to your out-of-pocket maximum. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the remainder of the year.

Under the Medical Options, you may decide whether to use in-network or out-of-network providers each and every time you need care. You also have the option of seeing any specialist physician without a referral. However, when you use network providers, you receive a higher level of benefit, called in-network benefits. If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your network and/or claims administrator for approval to visit an out-of-network specialist. Provided you have obtained approval from your network and/or claims administrator, your out-of-network care will be covered at the network benefit level. If an approval is not obtained prior to the visit to the specialist, the visit will be covered out-of-network.

For a detailed explanation of the eligible expenses and exclusions under the Medical Options, see "Covered Expenses" and "Excluded Expenses."

Key Features of the Medical Benefits Options

The following are key features of the PPO 750, PPO 1500, PPO 2500, and the Out-of-Area Options. See "Covered Expenses" for a list of specific covered expenses.

Medically necessary: Medical care is covered by the PPO 750, PPO 1500, PPO 2500, and Out-of-Area Options when the care is medically necessary, is an Eligible Expense, and it is not excluded from coverage. The PPO 750, PPO 1500 and PPO 2500 Coverage Options cover annual exams and well-child care at no cost to you when you utilize network providers. (Under the Out of Area Option, the same preventive services are covered at 100%.) Please note that just because a physician orders a service does not mean the service is medically necessary.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses billed by out-of-network providers under the Out-of-Area option is based on the usual and prevailing fee limits for a particular service or supply in that geographic location. Because participating providers in the Preferred Provider Organization (PPO) network have agreed to discounted fees, the usual and prevailing fee limits do not apply to in-network services. Please note that if you choose to receive services from an out-of-network provider while enrolled in the PPO 750, PPO 1500, or PPO 2500 Options, reimbursement will generally be based upon a percentage of Medicare allowable rates and you may be responsible for any unreimbursed amounts. **Please make sure you understand your financial responsibility when using an out-of-network provider.**

Individual annual deductible: Your annual deductible under the Out-of-Area, PPO 750, PPO 1500 and PPO 2500 Options is the amount of Eligible Expenses you must pay each year before your medical option coverage will start reimbursing you for services subject to coinsurance. After you satisfy the deductible, your selected medical option pays the appropriate percentage of the allowed amount for eligible covered medical services. If you are enrolled in the PPO 1500 or PPO 2500 Options, please read the following section on Family Deductibles.

Family annual deductible: Under the PPO 1500 and PPO 2500 Options, if more than one person is covered, all covered individuals will be subject to the Family Deductible. In these instances, the Individual Annual Deductible will not apply to any covered family members. Covered expenses that are paid out-of-pocket for all family members will be applied to the Family Deductible. Once the Family Annual Deductible has been met, the Plan will begin to pay coinsurance for covered services. (If the employee is the only person covered under the PPO 1500 or PPO 2500 Option, then the Individual Annual Deductible will apply.)

Under the PPO 750 and Out-of-Area Options, once the family annual deductible has been satisfied, all members of your family are eligible for reimbursement of eligible medical expenses, regardless of whether they have satisfied *individual* annual deductibles. Please note that you are not required to satisfy the Family Deductible in order for the Plan to begin paying a percentage of covered expenses. Once a covered person meets his/her individual deductible, the medical option will pay the appropriate percentage. Refer to "Medical Benefit Options Comparison" for more information regarding individual and family deductibles.

Claims: Participating PPO providers typically file claims for you; however, in some cases, you may be required to pay for services in advance and file a claim to receive reimbursement. You will need to file a claim if you receive services from an out-of-network provider or facility.

Annual out-of-pocket maximum: After you satisfy the annual out-of-pocket maximum for Eligible Expenses under the option you have selected for coverage, the medical option pays 100% of Eligible Expenses for the rest of the year.

- Under the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options, all amounts applied to the deductible, copayments, and coinsurance amounts, apply to the annual out-of-pocket maximum.

Pre-authorization: Call your Network/Claim Administrator (or HMO as applicable) in the following situations:

- To pre-authorize a surgery or hospitalization.
- If you are using out-of-network services, you must call your network and/or claims administrator to pre-authorize any surgery or hospitalization.
- If you need emergency care, you should contact your network and/or claims administrator within 48 hours after you receive initial care to ensure that your claim is processed at the in-network benefit level as soon as possible.
- **Injury by others:** If someone else injures you and this Plan pays a benefit, the Company will recover payment from the third party. (This practice is known as *subrogation*, which is described in more detail under "Claims" in the *Plan Administration* section.)

Prescription drug benefits: The PPO 750, PPO 1500, PPO 2500, and Out-of-Area Options cover medically necessary prescription drugs purchased at any retail pharmacy and offer discounted prescriptions at participating Express Scripts network pharmacies, including prescriptions for psychotherapeutic drugs. **Please note that you will pay an additional $5 per prescription if you use a retail pharmacy that is not part of the Express Advantage Network.** Please see "Retail Drug Coverage" for more information.

The PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options cover medically necessary prescriptions with copayments or coinsurance after satisfaction of the deductible when purchased at a participating retail pharmacy (up to a 30-day supply). (The PPO 750 and Out-of-Area Options have an annual $50 per person retail deductible. Under the PPO 1500 and PPO 2500 Options, the overall medical deductible also applies to retail and mail pharmacy purchases.) When you visit a network pharmacy, it is important that you provide your Prescription Drug ID card to ensure that your coinsurance is based upon the network price. If you visit an out-of-network pharmacy, you must submit your receipts to Express Scripts. Prescriptions purchased at an out-of-network pharmacy will be reimbursed based upon the network discount price and you will be responsible for the difference.

Prescription drugs covered by the Medical Benefits Options are described in "Covered Expenses" Refer to "Prescription Drug Benefits" for a description of the prescription drug benefit and to "Excluded Expenses" for a list of drugs not covered by the medical options.

Medical Benefit Options Comparison

The following tables provide a summary of features under the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options. Benefits are available for Eligible Expenses that are medically necessary and within the usual and prevailing fee limits for the Out-of-Area Option.

The tables show the amount or percentage you pay for Eligible Expenses, and you pay any amounts not covered by the options. If you are covered under the PPO 750, PPO 1500, PPO 2500 or Out-of-

Area Options and you use hospital-based services or services that require coinsurance, you must satisfy the individual or family annual deductible before the option pays benefits for Eligible Expenses.

As you review the following Comparison of Options tables, please keep the following points in mind:

- The out-of-pocket maximum under the medical options applies to coinsurance amounts you pay (i.e., for hospital services, including inpatient and outpatient care and surgery) as well as flat dollar co-payments. The out-of-pocket maximum also includes deductibles, but it does not include amounts not covered, or amounts exceeding the usual and prevailing fee limits for out-of-network services.
- Visit your network and/or claims administrator website or call to determine if your physician is a network provider.

For information regarding eligible medical expenses and expenses that are excluded from coverage, refer to "Covered Expenses" and "Excluded Expenses."

PPO 750 Option

Plan Features	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS		
Individual Annual Deductible	$750	$1,500
Family Annual Deductible**	$1,500	$4,500
Individual Annual Out-of-Pocket Maximum***	$4,950	$9,900
Family Annual Out-of-Pocket Maximum***	$9,900	$21,300
PREVENTATIVE CARE		
Annual Routine Physical Exam	$0	Not Covered
Adult Immunizations	$0	Not Covered
Pap Test	$0	40% coinsurance* if medically necessary: routine pap tests are not covered OON
Screening Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond-once every year)	$0	Not Covered
PSA Screening and Colorectal Screening (According to age guidelines – routine coverage begins at age 50)	$0	Not Covered
Well Child Office Visits and Immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	$0	Not Covered
MEDICAL SERVICES – All services must be medically necessary		
Primary Care Physician's Office Visit	$25 copayment	40% coinsurance*
Specialist Office Visit	20% coinsurance*	40% coinsurance*
TeleHealth/Doctors on Demand Effective January 1, 2017	$15 copayment	$0

Plan Features	In-Network	Out-of-Network
Gynecological Care Visit	$25 copayment	40% coinsurance* if medically necessary preventive care is not covered OON
Diagnostic Mammogram According to Age Guidelines, (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond – once every year)	$0 if part of office visit or at a non-hospital imaging center; otherwise 20% coinsurance*	40% coinsurance*
Prenatal Care	$0	40% coinsurance*
Pregnancy – Delivery by Obstetrician	$350 copayment Effective January 1,2017 20% coinsurance*	40% coinsurance*
Second Surgical Opinion	20% coinsurance*	40% coinsurance*
Urgent Care Center Visit	$50 copayment	40% coinsurance*
Chiropractic Care Visit	20% coinsurance* (max of 20 visits per year in-network and out-of-network combined per covered family member)	40% coinsurance* (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance*	Not Covered
Allergy Testing, Shots or Serum	$0 if administered in the physician's office. Deductible and coinsurance applies only if office visit is billed.	40% coinsurance*
Diagnostic X-ray and Lab	$0 if part of office visit or at a non-hospital imaging center. Otherwise, 20% coinsurance* after deductible.	40% coinsurance*
OUTPATIENT SERVICES – All services must be medically necessary		
Outpatient Surgery in Physician's Office	$25 copay PCP office; otherwise 20% coinsurance*	40% coinsurance*
Outpatient Surgery in a Hospital or Free Standing Surgical Facility (Including anesthesia and medically necessary assistant surgeon)	20% coinsurance*	40% coinsurance*

Plan Features	In-Network	Out-of-Network
Pre-admission Testing	$0 if part of office visit or at a non-hospital facility, otherwise 20% coinsurance.	40% coinsurance*
HOSPITAL SERVICES – All services must be medically necessary		
Inpatient Room and Board (Including intensive care unit or special care unit)	20% coinsurance*	40% coinsurance*
Ancillary Services (Including x-rays, pathology, operating room, and supplies)	20% coinsurance*	40% coinsurance*
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via my.envoyair.com within 30 days or these charges will not be covered.)	20% coinsurance* (separate calendar year deductible applies to baby)	40% coinsurance* (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance*	40% coinsurance*
Bariatric Surgery (Covered in-network only)	20% coinsurance*	Not Covered
Blood Transfusion	$0 if performed in physician's office. Otherwise 20% coinsurance*	40% coinsurance*
Organ Transplant	20% coinsurance*	40% coinsurance*
Emergency Ambulance	$0	$0
Emergency Room (Hospital) Visit	20% coinsurance*	Emergency Services: 20% coinsurance* All other services received in a hospital emergency room: 40% coinsurance*
OUT-OF-HOSPITAL CARE – All services must be medically necessary		
Convalescent and Skilled Nursing Facility Following Hospitalization	20% coinsurance* Max of 60 days (combined network and out-of-network care) per illness or injury. SNF admission must occur within 15 days of IP hospitalization.	40% coinsurance Max of 60 days (combined network and out-of-network care) per illness or injury. SNF admission must occur within 15 days of IP hospitalization.
Home Health Care Visit	$25 copayment per day	40% coinsurance*

Plan Features	In-Network	Out-of-Network
Hospice Care	20% coinsurance* if performed at a hospital; $25 copayment per day if home care	40% coinsurance*
OTHER SERVICES		
Vasectomy (Reversals are not covered)	20% coinsurance*	40% coinsurance*
Tubal Ligation	$0	40% coinsurance*
Infertility Treatment (Including in-vitro fertilization)	Not Covered	Not Covered
Radiation Therapy	No cost if performed in a physician's office; 20% coinsurance* if performed at a hospital	40% coinsurance*
Chemotherapy	No cost if performed in a physician's office; 20% coinsurance* if performed in a hospital or freestanding facility	40% coinsurance*
Kidney Dialysis (If the dialysis continues more than 12 months, participants must apply for Medicare)	No cost if performed in a physician's office; otherwise 20% coinsurance*	40% coinsurance*
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance*	40% coinsurance*
Hearing Aids	$3500 allowable per hearing aid. Replacement allowed every 36 months. 20% coinsurance*	$3500 allowable per hearing aid. Replacement allowed every 36 months. 40% coinsurance*
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Inpatient Mental Health Care	20% coinsurance*	40% coinsurance*
Alternative Mental Health Center – Residential Treatment	20% coinsurance*	40% coinsurance*
Alternative Mental Health Care Center – Intensive Outpatient and Partial Hospitalization	20% coinsurance*	40% coinsurance*
Outpatient Mental Health Care Visit	20% coinsurance*	40% coinsurance*
Marriage Counseling	Not Covered	Not Covered
Detoxification	20% coinsurance*	40% coinsurance*

Plan Features	In-Network	Out-of-Network
Chemical Dependency Inpatient Rehabilitation	20% coinsurance*	40% coinsurance*
Chemical Dependency Outpatient Rehabilitation	20% coinsurance*	40% coinsurance*
PRESCRIPTION MEDICATIONS		
Retail Deductible	$50 per person per calendar year	$50 per person per calendar year
Retail Refill Allowance (RRA)	Applies to maintenance prescription drugs. The first three times that you purchase a maintenance drug at a participating retail pharmacy, you may pay your retail copay or co-insurance. After the third purchase at retail, you will pay 100% of the drug's cost and the amount you pay will not count towards your out-of-pocket maximum. You must move your maintenance medications to Express Scripts' mail order pharmacy to receive coverage after your third fill.	
Retail Pharmacy* (Up to a 30 day supply)	Generic: 20% coinsurance ($10 Min/$50 Max) Preferred Brand: 30% coinsurance ($35 Min/$100 Max) Non-Preferred Brand: 50% coinsurance ($50 Min/$125 Max) An additional $5 copay will apply if using a non-preferred network pharmacy	Drug reimbursement is based on network pricing
Mail Service Pharmacy* (Up to a 90 day supply)	Generic: 20% coinsurance ($25 Min/$125 Max) Preferred Brand: 30% coinsurance ($75 Min/$200 Max) Non-Preferred Brand: 50% coinsurance ($125 Min/$275 Max)	Not Covered

Plan Features	In-Network	Out-of-Network
Prescription-filled Contraceptives	Oral Contraceptives, transdermal, and intravaginal contraceptives covered at 100% at mail order only. This includes both generic and brand name contraceptives. You will be responsible for the cost difference between generic and brand name medications if you select a brand name contraceptive that has a generic equivalent, unless your health care Provider determines that a generic contraceptive would be medically inappropriate. The cost difference you pay does not count toward your out-of-pocket maximum.	Not Covered
Prescription Drug Information	If you select a brand name drug when a generic equivalent is available, you will pay the generic 20% coinsurance plus the cost difference between brand and generic prices. Maximums do not apply in this situation and the cost difference you pay does not count towards your out-of-pocket maximum.	
Over-the-counter Medication	Not Covered	Not Covered
OTHER INFORMATION		
Pre-determination of Benefits (See Prior Authorization)	Recommended before hospitalization and surgery for all plans, for network and out-of-network.	Recommended before hospitalization and surgery for all plans, for network and out-of-network
Hospital Preauthorization (See Prior Authorization)	Required before hospitalization and recommended before outpatient surgery. Call your network/claims administrator for more information.	Recommended before hospitalization and surgery for all plans, for network and out-of-network. Call your network/claims administrator for more information.

*Coinsurance applies once you have satisfied the deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.

Once the Out-of-Pocket Maximum has been met, co-pays are waived.

PPO 1500 Option

Plan Features	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS		
Individual Annual Deductible (If more than one person is covered, the individual deductible will not apply)	$1,500	$3,000
Family Annual Deductible* (If more than one person is covered under this option, the Family Deductible applies to all family members.)	$3,000 True Family Deductible	$6,000 True Family Deductible
Individual Annual Out-of-Pocket Maximum** (If more than one person is covered, the individual Out-of-Pocket maximum will not apply)	$4,500	$9,000
Family Annual Out-of-Pocket Maximum** (If more than one person is covered under this option, the Family Out-of-Pocket Maximum applies to all members of the family.)	$12,900**	$25,800**
PREVENTATIVE CARE – All services must be medically necessary		
Annual Routine Physical Exam	$0	Not Covered
Adult Immunizations	$0	Not Covered
Pap Test	$0	40% coinsurance* if medically necessary: routine pap tests are not covered OON
Screening Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond-once every year)	$0	Not Covered
PSA Screening and Colorectal Screening (According to age guidelines-routine coverage begins at age 50)	$0	Not Covered

Plan Features	In-Network	Out-of-Network
Well Child Office Visits and Immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	$0	Not Covered
MEDICAL SERVICES – All services must be medically necessary		
Primary Care Physician's Office Visit	20% coinsurance*	40% coinsurance*
Specialist Office Visit	20% coinsurance*	40% coinsurance*
TeleHealth/Doctors on Demand Effective January 1, 2017	$40*	$0
Gynecological Care Visit	20% coinsurance*	40% coinsurance* if medically necessary preventive care is not covered OON
Diagnostic Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond – once every year)	20% coinsurance*	40% coinsurance*
Prenatal Care	$0	40% coinsurance*
Pregnancy – Delivery by Obstetrician	20% coinsurance*	40% coinsurance*
Second Surgical Opinion	20% coinsurance*	40% coinsurance*
Urgent Care Center Visit	20% coinsurance*	40% coinsurance*
Chiropractic Care Visit	20% coinsurance* (max of 20 visits per year in-network and out-of-network combined per covered family member)	40% coinsurance* (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance*	Not covered
Allergy Testing, Shots or Serum	20% coinsurance*	40% coinsurance*
Diagnostic X-ray and Lab	20% coinsurance*	40% coinsurance*
OUTPATIENT SERVICES – All services must be medically necessary		

Plan Features	In-Network	Out-of-Network
Outpatient Surgery in Physician's Office	20% coinsurance*	40% coinsurance*
Outpatient Surgery in a Hospital or Free Standing Surgical Facility (Including anesthesia and medically necessary assistant surgeon)	20% coinsurance*	40% coinsurance*
Pre-admission Testing	20% coinsurance*	40% coinsurance*
HOSPITAL SERVICES – All services must be medically necessary		
Inpatient Room and Board (Including intensive care unit or special care unit)	20% coinsurance*	40% coinsurance*
Ancillary Services (Including x-rays, pathology, operating room, and supplies)	20% coinsurance*	40% coinsurance*
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via my.envoyair.com within 30 days or these charges will not be covered.)	20% coinsurance*	40% coinsurance*
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance*	40% coinsurance*
Bariatric Surgery (Covered in-network only)	20% coinsurance*	Not Covered
Blood Transfusion	20% coinsurance*	40% coinsurance*
Organ Transplant	20% coinsurance*	40% coinsurance*
Emergency Ambulance	20% coinsurance*	20% coinsurance*
Emergency Room (Hospital) Visit	20% coinsurance*	Emergency: 20% coinsurance* Non-emergency: 40% coinsurance*
OUT-OF-HOSPITAL CARE – All services must be medically necessary		

Plan Features	In-Network	Out-of-Network
Convalescent and Skilled Nursing Facility Following Hospitalization	20% coinsurance* Max of 60 days (combined network and out-of-network care) per illness or injury. SNF admission must occur within 15 days of IP hospitalization.	40% coinsurance Max of 60 days (combined network and out-of-network care) per illness or injury. SNF admission must occur within 15 days of IP hospitalization.
Home Health Care Visit	20% coinsurance*	40% coinsurance*
Hospice Care	20% coinsurance*	40% coinsurance*
OTHER SERVICES		
Vasectomy (Reversals are not covered)	20% coinsurance*	40% coinsurance*
Tubal Ligation	$0	40% coinsurance*
Infertility Treatment (Including in-vitro fertilization)	Not Covered	Not Covered
Radiation Therapy	20% coinsurance*	40% coinsurance*
Chemotherapy	20% coinsurance*	40% coinsurance*
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance*	40% coinsurance*
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance*	40% coinsurance*
Hearing Aids	$3500 allowable per hearing aid. Replacement allowed every 36 months. 20% coinsurance*	$3500 allowable per hearing aid. Replacement allowed every 36 months. 40% coinsurance*
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Inpatient Mental Health Care	20% coinsurance*	40% coinsurance*
Alternative Mental Health Center – Residential Treatment	20% coinsurance*	40% coinsurance*
Alternative Mental Health Care Center – Intensive Outpatient and Partial Hospitalization	20% coinsurance*	40% coinsurance*
Outpatient Mental Health Care Visit	20% coinsurance*	40% coinsurance*
Marriage Counseling	Not Covered	Not Covered
Detoxification	20% coinsurance*	40% coinsurance*

Plan Features	In-Network	Out-of-Network
Chemical Dependency Inpatient Rehabilitation	20% coinsurance*	40% coinsurance*
Chemical Dependency Outpatient Rehabilitation	20% coinsurance*	40% coinsurance*
PRESCRIPTION MEDICATIONS		
Pharmacy Deductible (Retail and Mail Order*)***	Prescriptions are subject to the Deductible; however, certain preventive prescriptions bypass the deductible – contact Express Scripts for more information	Prescriptions are subject to the Deductible; however, certain preventive prescriptions bypass the deductible – contact Express Scripts for more information
Retail Refill Allowance (RRA)	Applies to maintenance prescription drugs. The first three times that you purchase a maintenance drug at a participating retail pharmacy, you may pay your retail copay or co-insurance. After the third purchase at retail, you will pay 100% of the drug's cost and the amount you pay will not count towards your out-of-pocket maximum. You must move your maintenance medications to Express Scripts' mail order pharmacy to receive coverage after your third fill.	
Retail Pharmacy* (Up to a 30 day supply)	Generic: 20% coinsurance ($10 Min/$50 Max) Preferred Brand: 30% coinsurance ($35 Min/$100 Max) Non-Preferred Brand: 50% coinsurance ($50 Min/$125 Max) An additional $5 copay will apply if using a non-preferred network pharmacy	Drug reimbursement at an OON pharmacy is based on network pricing

Plan Features	In-Network	Out-of-Network
Mail Service Pharmacy* (Up to a 90 day supply)	Generic: 20% coinsurance ($25 Min/$125 Max) Preferred Brand: 30% coinsurance ($75 Min/$200 Max) Non-Preferred Brand: 50% coinsurance ($125 Min/$275 Max)	Not Covered
Prescription-filled Contraceptives	Oral Contraceptives, transdermal, and intravaginal contraceptives covered at 100% at mail order only. This includes both generic and brand name contraceptives. You will be responsible for the cost difference between generic and brand name medications if you select a brand name contraceptive that has a generic equivalent, unless your health care Provider determines that a generic contraceptive would be medically inappropriate. The cost difference you pay does not count toward your out-of-pocket maximum.	Not Covered
Prescription Drug Information	If you select a brand name drug when a generic equivalent is available, you will pay the generic 20% coinsurance plus the cost difference between brand and generic prices. Maximums do not apply in this situation and the cost difference you pay does not count towards your out-of-pocket maximum.	
Over-the-counter Medication	Not Covered	Not Covered
OTHER INFORMATION		
Pre-determination of Benefits (See Prior Authorization)	Recommended before hospitalization and surgery for all plans, for network and out-of-network. Call BCBS for more information.	Recommended before hospitalization and surgery for all plans, for network and out-of-network. Call BCBS for more information.

Plan Features	In-Network	Out-of-Network
Hospital Preauthorization (See Prior Authorization)	Required before hospitalization and recommended before outpatient surgery. Call BCBS for more information.	Recommended before hospitalization and surgery for all plans, for network and out-of-network. Call BCBS for more information.

*Coinsurance applies once you have satisfied the deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.

**If more than one person is covered, the family deductible must be satisfied before coinsurance applies.

***If more than one person is covered, the family OOP maximum must be met before receiving 100% coverage. In general, an individual will not be required to pay more than the Affordable Care Act's out of pocket maximum for self-only coverage in 2016 ($6,850) unless an individual changes benefit options mid-year pursuant to a HIPAA special enrollment right.

****Certain Preventive medications bypass the deductible; however copays/coinsurance still applies.

PPO 2500 Option

Plan Features	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS		
Individual Annual Deductible *(If more than one person is covered, the individual deductible will not apply)*	$2,500	$5,000
Family Annual Deductible** *(If more than one person is covered, the individual deductible will not apply)*	$5,000 True Family Deductible	$10,000 True Family Deductible
Individual Annual Out-of-Pocket Maximum** (If more than one person is covered, the individual Out-of-Pocket maximum will not apply)	$6,450	$12,900
Family Annual Out-of-Pocket Maximum** (If more than one person is covered under this option, the Family Out-of-Pocket Maximum applies to all members of the family.)	$12,900**	$25,800**
PREVENTATIVE CARE – All services must be medically necessary		
Annual Routine Physical Exam	$0	Not Covered
Adult Immunizations	$0	Not Covered
Pap Test	$0	40% coinsurance* if medically necessary: routine pap tests are not covered OON
Screening Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond-once every year)	$0	Not Covered
PSA Screening and Colorectal Screening (According to age guidelines-routine coverage begins at age 50)	$0	Not Covered

Plan Features	In-Network	Out-of-Network
Well Child Office Visits and Immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	$0	Not Covered
MEDICAL SERVICES – All services must be medically necessary		
Primary Care Physician's Office Visit	20% coinsurance*	40% coinsurance*
Specialist Office Visit	20% coinsurance*	40% coinsurance*
TeleHealth/Doctors on Demand Effective January 1, 2017	$40*	$0
Gynecological Care Visit	20% coinsurance*	40% coinsurance* if medically necessary preventive care is not covered OON
Diagnostic Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond – once every year)	20% coinsurance*	40% coinsurance*
Prenatal Care	$0	40% coinsurance*
Pregnancy – Delivery by Obstetrician	20% coinsurance*	40% coinsurance*
Second Surgical Opinion	20% coinsurance*	40% coinsurance*
Urgent Care Center Visit	20% coinsurance*	40% coinsurance*
Chiropractic Care Visit	20% coinsurance* (max of 20 visits per year in-network and out-of-network combined per covered family member)	40% coinsurance* (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance*	Not covered
Allergy Testing, Shots or Serum	20% coinsurance*	40% coinsurance*
Diagnostic X-ray and Lab	20% coinsurance*	40% coinsurance*
OUTPATIENT SERVICES – All services must be medically necessary		
Outpatient Surgery in Physician's Office	20% coinsurance*	40% coinsurance*

Plan Features	In-Network	Out-of-Network
Outpatient Surgery in a Hospital or Free Standing Surgical Facility (Including anesthesia and medically necessary assistant surgeon)	20% coinsurance*	40% coinsurance*
Pre-admission Testing	20% coinsurance*	40% coinsurance*
HOSPITAL SERVICES – All services must be medically necessary		
Inpatient Room and Board (Including intensive care unit or special care unit)	20% coinsurance*	40% coinsurance*
Ancillary Services (Including x-rays, pathology, operating room, and supplies)	20% coinsurance*	40% coinsurance*
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via my.envoyair.com within 30 days or these charges will not be covered.)	20% coinsurance*	40% coinsurance*
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance*	40% coinsurance*
Bariatric Surgery (Covered in-network only)	20% coinsurance*	Not covered
Blood Transfusion	20% coinsurance*	40% coinsurance*
Organ Transplant	20% coinsurance*	40% coinsurance*
Emergency Ambulance	20% coinsurance*	20% coinsurance*
Emergency Room (Hospital) Visit	20% coinsurance*	Emergency: 20% coinsurance* Non-emergency: 40% coinsurance*
OUT-OF-HOSPITAL CARE – All services must be medically necessary		
Convalescent and Skilled Nursing Facility Following Hospitalization	20% coinsurance* Max of 60 days (combined network and out-of-network care) per illness or injury. SNF admission must occur within 15 days of IP hospitalization.	40% coinsurance Max of 60 days (combined network and out-of-network care) per illness or injury. SNF admission must occur within 15 days of IP hospitalization.
Home Health Care Visit	20% coinsurance*	40% coinsurance*
Hospice Care	20% coinsurance*	40% coinsurance*

Plan Features	In-Network	Out-of-Network
OTHER SERVICES		
Vasectomy (Reversals are not covered)	20% coinsurance*	40% coinsurance*
Tubal Ligation	$0	40% coinsurance*
Infertility Treatment (Including in-vitro fertilization)	Not Covered	Not Covered
Radiation Therapy	20% coinsurance*	40% coinsurance*
Chemotherapy	20% coinsurance*	40% coinsurance*
Kidney Dialysis (If the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance*	40% coinsurance*
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance*	40% coinsurance*
Hearing Aids	$3500 allowable per hearing aid. Replacement allowed every 36 months. 20% coinsurance*	$3500 allowable per hearing aid. Replacement allowed every 36 months. 40% coinsurance*
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Inpatient Mental Health Care	20% coinsurance*	40% coinsurance*
Alternative Mental Health Center – Residential Treatment	20% coinsurance*	40% coinsurance*
Alternative Mental Health Care Center – Intensive Outpatient and Partial Hospitalization	20% coinsurance*	40% coinsurance*
Outpatient Mental Health Care Visit	20% coinsurance*	40% coinsurance*
Marriage Counseling	Not Covered	Not Covered
Detoxification	20% coinsurance*	40% coinsurance*
Chemical Dependency Inpatient Rehabilitation (EAP approval required for employee cases resulting from regulatory or company policy violations)	20% coinsurance*	40% coinsurance*
Chemical Dependency Outpatient Rehabilitation (EAP approval required for employee cases resulting from regulatory or company policy violations)	20% coinsurance*	40% coinsurance*

Plan Features	In-Network	Out-of-Network
PRESCRIPTION MEDICATIONS		
Pharmacy Deductible (Retail and Mail Order)***	Prescriptions are subject to the Deductible; however, certain preventive prescriptions bypass the deductible – contact Express Scripts for more information	Prescriptions are subject to the Deductible; however, certain preventive prescriptions bypass the deductible – contact Express Scripts for more information
Retail Refill Allowance (RRA)	Applies to maintenance prescription drugs. The first three times that you purchase a maintenance drug at a participating retail pharmacy, you may pay your retail copay or co-insurance. After the third purchase at retail, you will pay 100% of the drug's cost and the amount you pay will not count towards your out-of-pocket maximum. You must move your maintenance medications to Express Scripts' mail order pharmacy to receive coverage after your third fill.	
Retail Pharmacy* (Up to a 30 day supply)	Generic: 20% coinsurance ($10 Min/$50 Max) Preferred Brand: 30% coinsurance ($35 Min/$100 Max) Non-Preferred Brand: 50% coinsurance ($50 Min/$125 Max) An additional $5 copay will apply if using a non-preferred network pharmacy	Drug reimbursement at an OON pharmacy is based on network pricing
Mail Service Pharmacy* (Up to a 90 day supply)	Generic: 20% coinsurance ($25 Min/$125 Max) Preferred Brand: 30% coinsurance ($75 Min/$200 Max) Non-Preferred Brand: 50% coinsurance ($125 Min/$275 Max)	Not Covered

Plan Features	In-Network	Out-of-Network
Prescription-filled Contraceptives	Oral Contraceptives, transdermal, and intravaginal contraceptives covered at 100% at mail order only. This includes both generic and brand name contraceptives. You will be responsible for the cost difference between generic and brand name medications if you select a brand name contraceptive that has a generic equivalent, unless your health care Provider determines that a generic contraceptive would be medically inappropriate. The cost difference you pay does not count toward your out-of-pocket maximum.	Not Covered
Prescription Drug Information	If you select a brand name drug when a generic equivalent is available, you will pay the generic 20% coinsurance plus the cost difference between brand and generic prices. Maximums do not apply in this situation and the cost difference you pay does not count towards your out-of-pocket maximum.	
Over-the-counter Medication	Not Covered	Not Covered
OTHER INFORMATION		
Pre-determination of Benefits (See Prior Authorization)	Recommended before hospitalization and surgery for all plans, for network and out-of-network	Recommended before hospitalization and surgery for all plans, for network and out-of-network
Hospital Preauthorization (See Prior Authorization)	Required before hospitalization and recommended before outpatient surgery	Recommended before hospitalization and surgery for all plans, for network and out-of-network

*Coinsurance applies once you have satisfied the deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.

**If more than one person is covered, the family deductible must be satisfied before coinsurance applies.

**If more than one person is covered, the family OOP maximum must be met before receiving 100% coverage. In general, an individual will not be required to pay more than the Affordable Care Act's out of pocket maximum for self-only coverage in 2016 ($6,850) unless an individual changes benefit options mid-year pursuant to a HIPAA special enrollment right.

***Certain Preventive medications bypass the deductible; however copays/coinsurance still applies.

Out of Area Coverage Option

Plan Features	In-Network and Out-of-Network
DEDUCTIBLES/MAXIMUMS	
Individual Annual Deductible (If more than one person is covered, the individual deductible will not apply)	$750
Family Annual Deductible (If more than one person is covered, the individual deductible will not apply)	$1,500
Individual/Family Annual Out-of-Pocket Maximum*	$4,950/$9,900
PREVENTIVE CARE	
Annual Routine Physical Exam, Including Well Woman Exam	Covered at 100%
Adult Immunizations	Covered at 100%
Pap Test	Covered at 100%
Screening Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond-once every year)	Covered at 100%
PSA Screening and Colorectal Screening (According to age guidelines – routine coverage begins at age 50)	Covered at 100%
Well Child Office Visits and Immunizations (Preventive Care based on ***USPSTF Grade A & B recommendations and CDC guidelines***)	Covered at 100%
MEDICAL SERVICES	
Primary Care Physician's Office Visit	20% coinsurance*
Specialist Office Visit	20% coinsurance*
Gynecological Care Visit	20% coinsurance*
Diagnostic Mammogram	20% coinsurance* (if medically necessary); routine mammograms are covered according to specific guidelines – refer to Mammograms in "Covered Expenses"
Pregnancy – Physician Services	20% coinsurance*
PSA and Colorectal Diagnostic Exam	20% coinsurance*

Plan Features	In-Network and Out-of-Network
Second Surgical Opinion	20% coinsurance*
Urgent Care Center Visit	20% coinsurance*
Chiropractic Care Visit	20% coinsurance* (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance*
Acupuncture: Medically Necessary Treatment (Performed by a Certified Acupuncturist) only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury	20% coinsurance*
Allergy Care	20% coinsurance*
Diagnostic X-ray and Lab	20% coinsurance*
OUTPATIENT SERVICES	
Outpatient Surgery in Physician's Office	20% coinsurance*
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance*
Pre-admission Testing	20% coinsurance*
HOSPITAL SERVICES	
Inpatient Room and Board (Including intensive care unit or special care unit)	20% coinsurance*
Ancillary Services (Including x-rays, pathology, operating room, and supplies)	20% coinsurance*
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via my.envoyair.com within 60 days or these charges will not be covered.)	20% coinsurance*
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance*

Plan Features	In-Network and Out-of-Network
Blood Transfusion	20% coinsurance*
Organ Transplant	20% coinsurance*
Emergency Ambulance	20% coinsurance*
Emergency Room (Hospital) Visit	20% coinsurance*
OUT-OF-HOSPITAL CARE	
Convalescent and Skilled Nursing Facility Following Hospitalization	20% coinsurance* (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance*
Home Infusion Therapy	20% coinsurance*
Hospice Care	20% coinsurance*
OTHER SERVICES	
Tubal Ligation or Vasectomy (Reversals are not covered)	Tubal ligation covered at 100% Vasectomy: 20% coinsurance*
Infertility Treatment	Not Covered
Radiation Therapy	20% coinsurance*
Chemotherapy	20% coinsurance*
Kidney Dialysis (If the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance*
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance*
MENTAL HEALTH AND CHEMICAL DEPENDENCY	
Inpatient Mental Health Care	20% coinsurance*
Alternative Mental Health Center	20% coinsurance*
Outpatient Mental Health Care Visit	20% coinsurance*
Marriage Counseling	Not Covered
Detoxification (See details under “Covered Expenses”)	20% coinsurance*
Chemical Dependency	20% coinsurance*
Inpatient Chemical Dependency Rehabilitation	20% coinsurance*

Plan Features	In-Network and Out-of-Network
Outpatient Chemical Dependency Rehabilitation	20% coinsurance*
PRESCRIPTION MEDICATIONS	
Pharmacy Deductible – Retail	$50 per person per calendar year
Retail Pharmacy (Up to a 30 day supply)	Retail Card Program Generic: 20% coinsurance ($10 Min/$50 Max) Preferred Brand: 30% coinsurance ($35 Min/$100 Max) Non-Preferred Brand: 50% ($50 Min/$125 Max) If you select a brand-name drug when a generic equivalent is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply. An additional $5 copay will apply if using a non-preferred network pharmacy
Mail Service Pharmacy (Up to a 90 day supply)	Generic: 20% coinsurance ($25 Min/$125 Max) Preferred Brand: 30% coinsurance ($75 Min/$200 Max) Non-Preferred Brand: 50% coinsurance ($125 Min/$275 Max) If you select a brand-name drug when a generic equivalent is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply.
Retail Service Pharmacy (Up to a 90 day supply) For Long-Term medications (taken for 3 months or more) beginning with 4th fill.	Member pays 100% of cost for maintenance drugs starting with 4th fill at retail Move your maintenance medications to the Express Scripts Mail Order pharmacy prior to your fourth fill to receive coverage.
Oral Contraceptives (Available only thru mail service)	Generic oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices, unless your health care Provider determines that a generic contraceptive would be medically inappropriate.
Over-the-counter Medication	Not Covered
OTHER INFORMATION	
CHECKFIRST (Predetermination of benefits via your network/claim administrator)	Call BCBS for a form, complete and mail

*Coinsurance applies once you have satisfied the deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.

Disclaimer: If the provisions in the preceding summary chart differ from the other descriptions in this EBG, the EBG descriptions outside of the summary chart will prevail.

Special Provisions

Missing Persons/Uncashed Checks: If the Network/Claims Administrator cannot locate a Plan participant, after making a reasonably diligent effort, including by giving written notice addressed to the Plan participant's last known address as shown by the records of the Network/Claims Administrator, the amount payable to the Plan participant is forfeited and shall be considered the

property of the Plan. Plan Participants may contact the Network/Claims Administrator to claim uncashed checks. Similarly, if a Participant fails to cash a check for benefits under the Plan, the amount payable to the Participant may be forfeited.

Specialists: Under the Medical Benefits Options, you may decide whether to use in-network or out-of-network providers each and every time you need care. You also have the option of seeing any specialist physician without a referral. However, when you use network providers, you receive a higher level of benefit, called in-network benefits. If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your network and/or claims administrator for approval to visit an out-of-network specialist. Provided you have obtained approval from your network and/or claims administrator, your out-of-network care may be covered at the network benefit level. If an approval is not obtained prior to the visit to the specialist, the visit will be covered out-of-network.

For a detailed explanation of the eligible expenses and exclusions under the Medical Benefits Options, see "Covered Expenses" and "Excluded Expenses."

Individual annual deductibles: For most covered expenses, the deductible must be met before benefits are payable. The deductible is satisfied with covered expenses that the Medical Benefits Option otherwise pays at a percentage (coinsurance) of the covered expense. You must pay all of the covered expense yourself until the amount you have paid equals the deductible amount shown for the calendar year under the Medical Benefits Option that you are enrolled in – only then will the Medical Benefits Option begin to pay its percentage of covered expenses. If you are enrolled in the PPO 750 Option, and you are required to pay a flat dollar amount (copay) of the covered expense (e.g., PCP or urgent care) that dollar amount you pay for your copay does not count towards satisfaction of your deductible. However, the copay amounts will apply to your out-of-pocket maximum.

Under the PPO 1500 and PPO 2500 Options, your deductible applies toward eligible medical and prescription drug expenses. Under the PPO 750 and Out-of-Area Options, you have a separate annual retail pharmacy deductible that must be satisfied.

If you have elected medical coverage under the PPO 1500 or PPO 2500 Options, and you enroll at least one other family member with you in this coverage, the Individual Annual Deductible will not apply for any members of your family. All eligible expenses incurred and paid by covered family members under the PPO 1500 and PPO 2500 Options will apply towards satisfaction of the Family Deductible.

Family annual deductible: For most covered expenses, the deductible must be met before benefits are payable. The Family Deductible is satisfied with covered expenses that the Medical Benefits Option otherwise pays at a percentage (coinsurance) of the covered expense. You must pay all of the covered expense yourself until the amount you have paid equals the individual annual deductible amount shown for the calendar year under the Medical Benefits Option that you are enrolled in – the amount applied to each family member's individual annual deductible also applies towards satisfaction of the Family Annual Deductible. Once the Family Annual Deductible amount has been satisfied, the Medical Benefits Option begins to pay its percentage of covered expenses for all family members. If you are enrolled in the PPO 750 Option, and you are required to pay a flat dollar amount (copay) of the covered expense (e.g., PCP or urgent care) that dollar amount you pay for your copay does not count towards satisfaction of your deductible.

Under the PPO 1500 and PPO 2500 Options, your deductible applies toward eligible medical and prescription drug expenses. Under the PPO 750 and Out-of-Area Options, you have a separate annual retail pharmacy deductible that must be satisfied.

If you have elected medical coverage under the PPO 1500 or PPO 2500 Options, and you enroll at least one other family member with you in this coverage, the Individual Annual Deductible will not apply for any members of your family. All eligible expenses incurred and paid by family members under the PPO 1500 and PPO 2500 Options will apply towards satisfaction of the Family Deductible.

Individual annual out-pocket-maximum: Only each covered individual's portion of covered expense can be used to meet his/her individual annual out-of-pocket maximum. Once the individual annual out-of-pocket is met for the calendar year, the Medical Benefits Option will pay 100% of covered expenses for the remainder of the calendar year. Copays, coinsurance and deductibles count toward satisfaction of the annual out-of-pocket maximum.

If you have elected medical coverage under the PPO 1500 or PPO 2500 Options, and you enroll at least one other family member with you in this coverage, the Individual Annual Out-of-Pocket will not apply to you and any members of your family enrolled in such coverage. In general, an individual will not be required to pay more than the Affordable Care Act's out of pocket maximum for self-only coverage in 2016 ($6,850) unless an individual changes benefit options mid-year pursuant to a HIPAA special enrollment right. All eligible expenses incurred and paid by family members under the PPO 1500 and PPO 2500 Options will apply towards satisfaction of the Family Out-of-Pocket Maximum.

Family annual out-of-pocket maximum: Copay, coinsurance and deductibles count towards satisfaction of the Family Annual Out-of-Pocket Maximum. Once the Family Annual Out-of-Pocket Maximum is met, the Plan pays covered expenses at 100% for all family members for the remainder of the calendar year.

If you have elected medical coverage under the PPO 1500 or PPO 2500 Options, and you enroll at least one other family member with you in this coverage, the Individual Annual Out-of-Pocket Maximum will not apply to members of your family enrolled in such coverage. Once the Individual Annual Out-of-Pocket Maximum has been satisfied, the Plan will pay covered expenses at 100% for such Individual for the remainder of the calendar year. In general, an individual will not be required to pay more than the Affordable Care Act's out of pocket maximum for self-only coverage (in 2016 this amount is $6,850; it increases to $7,150 for 2017) unless an individual changes benefit options mid-year pursuant to a HIPAA special enrollment right. All eligible expenses incurred and paid by family members under the PPO 1500 and PPO 2500 Options will apply towards satisfaction of the Family Out-of-Pocket Maximum.

Medical Discount Program: The Medical Benefits Options offer a voluntary preferred provider organization (PPO), which is a network of physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services. The Medical Discount Program helps save you and the Company money when you or a covered dependent needs medical care and chooses a participating provider.

This discount is automatic when you present your Medical Benefits Option ID card to a PPO provider, even if you are enrolled in the Out-of-Area Option. PPO network providers who contract with your network and/or claims administrator agree to provide services and supplies at discounted rates. When you use a network provider, you are not responsible for the difference between the amount charged by the network provider and the amount allowed by their contractual agreement with

your network and/or claims administrator. Please keep in mind that some providers charge more than others for the same services. For this reason, using a participating provider may not always be the least expensive alternative. However, you will always receive a discount off that provider's normal fees.

Contact your network and/or claims administrator to learn more details about this Medical Discount Program feature or go to your network and/or claims administrator's website for a list of PPO providers in your area. Because these network providers may change, you should confirm that your physician is part of the network whenever you make an appointment.

Please keep in mind the following situations when using PPO providers:

- If you go to a PPO hospital but receive services from a physician who is not a PPO provider, you receive the PPO discount for hospital charges, but the physician's fee is not eligible for the discount.
- If you use a PPO physician or hospital, charges for your lab services may not be eligible for the PPO discount if your physician or hospital uses a lab that is not part of the PPO network.
- Whenever possible, be sure to check with your provider in advance to ensure you receive the maximum discount.

Out-of-Network Services

- Under the PPO 750, PPO 1500 and PPO 2500 Options, if you go to a provider who is not part of the network, you are still covered for eligible medically necessary services; however, coverage is at a lower level of benefits (out-of-network benefit level) and you must first satisfy your out-of-network deductible.
- At the out-of-network benefit level, you pay an annual per person per year deductible and higher out-of-pocket coinsurance amounts – for most services, the plan pays 60% and you pay the remaining 40% of covered out-of-network charges, after you satisfy the annual deductible. Additionally, you must pay any amount of the provider's billed fee that exceeds the out-of-network reimbursement rates which are based upon a percentage of the Medicare allowable rate. Make sure you understand your financial obligation when before you elect to go out-of-network. Each time you or your covered dependent needs medical care, you choose whether to use a network or out-of-network provider.
- Special rules apply for "Emergency" services as defined in the Glossary. In this case, you will pay the same coinsurance that applies to in-network services. However, in some cases, the provider may separately bill you for unreimbursed charges.

Preventive Care

- Preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages. Non-routine tests for certification, sports or insurance are not covered unless Medically Necessary.
- The Company provides non-grandfathered group health plans that comply with the PPACA preventive care requirements.
- Preventive care focuses on evaluating your current health status when you are symptom free.
- Preventive services include those performed on a person who:

  - o has not had a preventive screening done before and does not have symptoms or other a documented related existing care related to the outcomes of the screening
  - o has had diagnostic screenings that were normal after which your Physician recommends future preventive screening
  - o has a preventive service done that results in a therapeutic service done at the same time (e.g. polyp removal during a preventive colonoscopy)
- The Company follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. To get a full list of In-Network preventive care covered at no cost to you visit, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm or https://www.healthcare.gov/preventive-care-benefits/
- Some preventive services have age and frequency limitations. These limitations can be based on Medical Necessity, medical review boards of the carriers in which we partner with to provide health care services and PPACA. Call your Network/Claim Administrator for details on coverage.
- If you receive preventive care at any location other than a Physician's office such as Urgent Care or emergency room, or from an Out-of-Network Provider, services may not be covered at 100%.
- Your health care Provider determines how you are billed for all health plan expenses. When a service is performed for the purpose of preventive screening and is appropriately billed as such by your Provider, then it will be covered under preventive services.

Under the PPO 750, PPO 1500 and PPO 2500 Options, in-network preventive care will be covered at 100%, without having to meet the annual deductible. (See "Medical Benefit Options Comparison" for details).

Under the Out-of-Area Option preventive care will be covered at 100% in-network or out-of-network, without having to meet the annual deductible. (See "Medical Benefit Options Comparison" for details).

Primary Care Physicians

PCPs practice in pediatrics, family practice, general practice, gynecology or internal medicine. You are encouraged to establish a relationship with a PCP. (If you are covered under the PPO 750 Option, you will pay a copay when you use a PCP or retail clinic.)

Specialist Care

To receive the network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use a network specialist, and services must be eligible under the terms of the Plan. To receive the network level of benefits for mental health services, you must contact your network and/or claims administrator.

If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your PCP or your network and/or claims administrator to determine if a referral to an out-of-network specialist is needed. In these *rare* instances, your out-of-network care is covered at the network benefit level, but only with prior approval through your network and/or claims administrator.

After you have enrolled, you will receive an ID card from your network and/or claims administrator indicating that you and your covered dependents are covered by the Plan. The ID card includes important phone numbers and should be presented each time you go to a network physician, other provider, or hospital.

Care while traveling: If you have a medical emergency while traveling, get medical attention immediately. If you need urgent (not emergency) care, you should call your Network/Claims Administrator for a list of network providers and urgent care facilities. However, if it is after hours, seek treatment but call your network and/or claims administrator within 48 hours. If you go to a network provider, you should only have to pay your copayment or deductible/coinsurance and your claim should be filed for you.

If you have a medical emergency and go to an out-of-network provider, you or a family member should call your network and/or claims administrator within 48 hours of your care to ensure that your claim is processed at the in-network level as soon as possible. You will need to submit a claim, but are eligible for the network level of benefits if you follow these procedures.

Continuing care: In the event you are newly enrolled in a Medical Benefits Option, and you or a covered family member has a serious illness, or you or your spouse are in the 20th (or later) week of pregnancy, you may ask your network and/or claims administrator to evaluate your need for continuing care. You may be eligible to continue with your current care provider at the network benefit level, even if that provider is not part of the network. Contact your network and/or claims administrator for more information.

Copayments vs. coinsurance: What you pay for eligible medical services depends on where you receive those services and the Medical Benefits Option you are covered under. Under the PPO 750 Option, you pay a fixed copayment for some in-network services such as primary physician office visits, including any tests or treatment received during that visit.

For services received in a network hospital-based setting, you pay a 20% coinsurance (a percentage of the cost) after satisfying your in-network deductible. For eligible out-of-network services, you must first satisfy an annual per person deductible, and then you pay the higher out-of-network coinsurance amount.

Deductibles: For eligible services, you pay an annual deductible, whether in or out-of-network.

Emergency care: If you have a medical emergency, go directly to an emergency facility. You or a family member must call your network and/or claims administrator within 48 hours of your emergency care to be eligible for the network benefit level. You should arrange any follow-up treatment through your physician. If you receive services at an out-of-network facility, you will need to submit a claim.

Filing claims: In most cases, when you use network providers, they file your claims for you.

Leaving the service area: With the exception of the annual enrollment period or pursuant to a HIPAA special enrollment event as explained in “Life Events and Special Enrollment Events”, the only other time you may change your medical election is if you relocate out of your network service area.

If you move out of your network service area, you will only be eligible for the Out-of-Area Option. You must contact the Benefits Service Center to process a relocation Life Event within 60 days of the event. (Effective January 1, 2017, your time frame for filing a Life Event is 30 days.) This allows you

to update your records and make a new benefits coverage selection, if applicable. If you do not notify the Benefits Service Center of your election, you will be enrolled in a plan offered in your new location. (See the *General Enrollment* section.)

Network administrator: Your network and/or claims administrator establishes standards for participating providers, including physicians, hospitals, and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges, and medical practice records. They also periodically monitor whether participating providers continue to meet network standards. The network administrator performs all these selection and accreditation activities.

When you use network providers, you receive a higher level of benefits, called in-network benefits.

TeleHealth (effective January 1, 2017): If you have a minor medical illness or injury, general medical services are available. Simply download the Doctor on Demand app, enter the information from your medical ID card and a form of payment.

Urgent care: If you are in your network service area and need urgent care, but you do not have an actual emergency, contact your network and/or claims administrator first and they will direct you to an appropriate place for care.

Health Maintenance Organizations (HMOs)

HMOs are insured programs whose covered services are paid by the HMO. Triple-S Salud Health Maintenance Organization (HMO) is offered to employees living in Puerto Rico and the U.S. Virgin Islands.

Please note that effective January 1, 2017, the Triple-S Salud HMO will no longer be offered.

HMOs include a network of physicians, hospitals, and other medical service providers. Your medical care is only covered when you use network providers. When you enroll in an HMO, a primary care physician (PCP) usually coordinates your medical care. Most HMOs require you to obtain a referral from your PCP before receiving care from a specialist. You may choose any participating primary care provider who is available and accepting new patients. You may also designate a pediatrician as a primary care provider for a child and see a health care professional specializing in gynecology or obstetrics without prior authorization or referral.

Features of the HMO includes:

- A network of providers
- A primary care physician who coordinates your covered medical care
- Low copayments for covered services
- Covered preventive care
- No claims to file

If you elect an HMO, your HMO coverage replaces medical coverage offered through the self-funded medical options. Your benefits, including prescription drugs from physicians and dentists, as well as mental health care, are covered according to the rules of the HMO you select. For example, some HMOs do not cover dental prescriptions.

Under most HMOs, chemical dependency rehabilitation for HMO participants will be coordinated by the Employee Assistance Program (EAP), and will be covered as described in "Covered Expenses." However, some HMOs provide their own chemical dependency rehabilitation programs to comply with state insurance laws. Detoxification is covered under the HMO.

HMOs provide their members with comprehensive health care services for a fixed monthly payment.

The HMO offered under the Plan is completely independent of the Company. Because each HMO is an independent organization, the benefits, restrictions, and conditions of coverage vary from one HMO to another and the Company cannot influence or dictate the coverage provided.

Under the Plan, Company-recognized Domestic Partners of employee participants the Plan will be eligible to be covered under the Triple-S Salud HMO. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children) and this option will no longer be available.**

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

Benefits

If you enroll in an HMO, you will receive information from the HMO describing the services and exclusions of that HMO. Review that material carefully. Benefits provided by the HMO often differ from benefits provided under the other medical plans offered by the Company.

Most of your other elections are not affected by your decision to participate in an HMO.

HMO Contact Information

HMO Name	HMO Customer Service Phone No.	Website Address	Group Numbers
TRIPLE-S, Inc. – Puerto Rico	1-787-749-4777	http://www.ssspr.com/	1-08500

Additional Rules for HMOs

Problems and Complaints

Triple-S HMO has a grievance procedure or policy to appeal claim denials or other issues involving the HMO. Call Triple-S for information on filing complaints or grievances.

If You and Your Spouse Work for the Company

If you and your spouse enroll in Triple-S, the entire family unit is covered in the male employee's name because of HMO administrative procedures. If the male spouse takes a Leave of Absence (LOA), coverage for the entire family unit is transferred to the female spouse for the duration of the leave. Special rules apply for same-sex married couples or domestic partners.

Children Living Outside the Service Area

If your child does not live with you, either because the child is a student or because you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO) (see "Qualified Medical Child Support Order" in the *Additional Health Benefit Rules* section), you must contact the HMO to find out whether the child can be covered. If the HMO cannot cover the child, you may be required to select one of the other medical options.

Termination of Coverage

Your HMO coverage terminates on the date your employment terminates or you move out of the HMO service area. If your employment terminates, you may be eligible to continue HMO coverage under COBRA. You may also apply for individual HMO coverage.

Following is special information about termination of coverage that applies to HMOs:

- **Leaving the service area:** With the exception of the annual enrollment period, the only other time you may change your election for HMO coverage is if you move out of the HMO's service area or pursuant to a HIPAA special enrollment event as explained in "Life Events and Special Enrollment Events." If you move out of your HMO's service area, you may register this move as a Life Event on my.envoyair.com, and enroll in the Plan's medical option offered for your new area. To make another election following your move, call the Benefits Service Center within 30 days of your move. If you do not notify the Benefits Service Center of your election, you will be enrolled in a medical option offered in your new area and will receive a confirmation statement indicating your new coverage
- **Active employees over age 65:** If you or your covered spouse reaches age 65 and becomes eligible for Medicare while covered under an HMO, most HMOs allow you to continue coverage. Coordination of benefits applies. The HMO is primary and Medicare is secondary (as explained in Coordination of Benefits) as long as you are an active employee.

Prior Authorization and Pre-Determination for Certain Medical Services

If you are covered by the PPO 750, PPO 1500, PPO 2500 or Out-of-Area Options, contacting your Network/Claim Administrator before receiving services allows you to find out if:

- The recommended service or treatment is covered by your selected Medical Benefits Option.
- Your physician's proposed charges fall within the Plan's out-of-network reimbursement rates or if covered under the Out-of-Area option, if your physician's proposed charges fall within the usual and prevailing fee limits. If you are covered by the PPO 750, PPO 1500 or PPO 2500 Option and you are using a PPO provider, the provider's fees are not subject to the usual and prevailing fee limits. However, you may want to contact your Network/Claims Administrator (or HMO, as applicable) to determine if the proposed services are covered under your selected Medical Benefit Option or to obtain cost information for different in-network providers.

Please note that even if you contact your Network/Claim Administrator for a pre-determination of benefits in advance of receiving services, your Network/Claim Administrator may make adjustments upon receipt of your claim based on the treatment and the Plan's allowed amount. Payment of a claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

If you are having outpatient surgery, your Network/Claims Administrator (as part of the Hospital Pre-authorization process) will determine the Medical Necessity of your proposed surgery before making a pre-determination of benefits. You Network/Claim Administrator will mail you a written response.

For hospital stays, your Network/Claim Administrator (or HMO as applicable) can predetermine the amount payable by the Plan. A pre-determination does not pre-authorize the length of a hospital stay or determine Medical Necessity. You must call your Network/Claims Administrator for pre-authorization (see "Prior Authorization").

Prior Authorization Recommended	
Assistant surgeon	A fee for an assistant surgeon is only covered when there is a demonstrated Medical Necessity. To determine if there is a Medical Necessity, you should contact your Network/Claims Administrator.
Multiple Surgical Procedures	If you are having Multiple Surgical Procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgeon. You can contact your Network/Claims Administrator to find out how the Plan reimburses the cost for any additional procedures.
Wellness Preventive Services	Contact your Network/Claims Administrator to determine if your option covers a specific preventive service for a particular medical condition.

Pre-Authorization

You or your providers, acting on your behalf, are required to request pre-authorization from your Network/Claims Administrator in the following circumstances. If you are using In-Network Providers, your Provider will call for you. If you are using Out-of-Network Providers, you must call yourself (or a family member can call on your behalf).

If you do not contact your Network/Claim Administrator, your expenses are still subject to review and will not be covered under the Plan if they are considered not Medically Necessary. Failure to pre-authorize may result in your expenses not being covered. If you are enrolled in one of the self-funded Medical Benefit Options, request pre-authorization by calling your Network/Claim Administrator. If you are covered by an HMO, contact your HMO before any Hospitalization.

If your physician recommends surgery or hospitalization, ask your physician for the following information before calling your Network/Claim Administrator for pre-authorization:

If your physician recommends surgery or hospitalization ask your physician for the following information:

- Diagnosis and diagnosis code
- Clinical name of the procedure and the CPT code

- Description of the service
- Estimate of the charges
- Physician's name and telephone number
- Name and telephone number of the hospital or clinic where surgery is scheduled.

If your illness or injury prevents you from personally contacting your Network/Claim Administrator, any of the following may call on your behalf:

- A family member or friend
- Your physician
- The hospital

Your Network/Claim Administrator will tell you:

- Whether the proposed treatment is considered medically necessary and appropriate for your condition
- The number of approved days of hospitalization
- In some cases, your Network/Claim Administrator may refer you for a consultation before surgery or hospitalization will be authorized. To avoid any delays in surgery or hospitalization, notify your Network/Claim Administrator as far in advance as possible

After you are admitted to the hospital, your Network/Claim Administrator provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, your Network/Claim Administrator consults with your physician and hospital to verify the need for any extension of your stay. If you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness you must contact your Network/Claim Administrator again to authorize any additional hospitalization.

PreAuthorization Required	
• Before any hospital admission, • Before detoxification, • Within 48 hours (or the next business day if admitted on a weekend) following emergency care, • Before Outpatient surgery to ensure that the surgery is considered Medically Necessary. (If you do not call, you may be subject to a retrospective review of the surgery to determine whether it was Medically Necessary. This means you or your Physician may be asked to provide medical documentation to support the Medical Necessity.) • Before you contemplate or undergo any organ transplant (If you do not call, your claim will be denied.) • Weight reduction: Hospitalization, surgery, treatment, and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact your Network/Claim Administrator to determine if treatment is covered. • **Home Health Care if medically necessary**	The Plan requires that you pre-authorize your coverage to ensure that these benefits are medically necessary and covered under the plan. **If you do not pre-authorize you may be responsible for the full amount of the charges for the procedure or service.**

*The list above is not comprehensive. Contact your Network/Claim Administrator for more information.

Please note that obtaining prior approval does not guarantee that benefits will be paid. Your Network/Claim Administrator reserves the right to make adjustments upon receipt of the final claim papers if the actual service differs from the pre-authorization information that was submitted.

Please note that claims are processed in order of receipt. Payment of claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

Covered Expenses

This section contains descriptions of the eligible medical expenses (listed alphabetically) that are covered under the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options when medically necessary. Benefits for some of these eligible expenses vary depending on the Medical Benefits Option you have selected and whether or not you use network providers. The "Medical Benefit Options Comparison" demonstrates how most services are covered.

For a list of items that are excluded from coverage, refer to "Excluded Expenses."

Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) for diagnosed illness or injury, only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury. (Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective—such as glaucoma, hypertension, acute low back pain, infectious disease, allergy, and the like).

Allergy care: Charges for medically necessary physician's office visits, allergy testing, shots, and serum are covered. (See "Excluded Expenses" for allergy care not covered under the Plan).

Ambulance: Medically necessary professional ambulance services and air ambulance once per illness or injury to and from:

- The nearest hospital qualified to provide necessary treatment in the event of an emergency
- The nearest hospital or convalescent or skilled nursing facility for inpatient care

Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient's medical condition requires immediate medical attention for which ground ambulance services might compromise the patient's life. Ambulance services are only covered in an emergency and only when care is required en route to or from the hospital.

Ancillary charges: Ancillary charges including charges for hospital services, supplies, and operating room use.

Anesthesia expenses: Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.

Assistant surgeon: The Medical Benefits Options only cover assistant surgeon's fees when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, contact your Network/Claims Administrator (or HMO, if applicable).

Bariatric surgeries: Bariatric surgeries (including but not limited to Gastric bypass, LAP Band, etc.) will be covered in-network only.

Blood: Coverage includes blood, blood plasma, and expanders. Benefits are paid only to the extent there is an actual expense to the participant.

Chiropractic care: Coverage includes medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license. You are limited to 20 visits per year for combined network and out-of-network chiropractic care.

Convalescent or skilled nursing facilities: These facilities are covered at 50% of the most common semi-private room rate in that geographic area for inpatient hospital expenses for up to 60 days per illness (for the same or related causes) after you are discharged from the hospital for a covered inpatient hospital confinement of at least three consecutive days. Under the PPO 750 Option, these facilities are covered the same as hospitalization, except there is a combined maximum stay of 60 days per illness or injury for network and out-of-network facilities.

To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital and be recommended by your physician for the condition which caused the hospitalization.

Eligible Expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician, and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement, and, your network/claims administrator must approve your stay. Custodial Care is not covered.

Cosmetic surgery: Medically necessary expenses for cosmetic surgery are only if they are incurred under either of the following conditions:

- As a result of a non-work related injury
- For replacement of diseased tissue surgically removed.

Other cosmetic surgery is not covered because it is not medically necessary.

Dental care: Dental expenses for medically necessary dental examination, diagnosis, care, and treatment of one or more teeth, the tissue around them, the alveolar process, or the gums, only when care is rendered for:

- Accidental injury(ies) to sound natural teeth, in which both the cause and the result accidental, due to an outside and unforeseen traumatic force
- Fractures and/or dislocations of the jaw
- Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury (as set forth in the first bullet under Dental Care above).

Detoxification: Detoxification is covered when alcohol and drug addiction problems are sufficiently severe to require immediate inpatient medical and nursing care services. Contact your Network/Claim Administrator (or HMO as applicable) for authorization.

Dietician services: Under the PPO 750 Option, coverage includes services recommended by your network provider and provided by a licensed network dietician. Dietician services are not covered under the PPO 1500, PPO 2500 or Out-of-Area Options.

Durable medical equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME resulting from normal wear and tear is not covered.

Coverage includes the initial purchase of eyeglasses or contact lenses required because of cataract surgery.

Emergency room: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call your Network/Claim Administrator within 48 hours of an emergency resulting in admission to the hospital.

Facility charges: Charges for the use of an outpatient surgical facility, when the facility is either an outpatient surgical center affiliated with a hospital or a free-standing surgical facility.

Hearing care: Covered expenses include medically necessary hearing exams and up to one hearing aid for each ear every 36 months up to a maximum allowed benefit of $3,500 per hearing aid. Cochlear implants and osseointegrated hearing implant systems (such as BAHAs) are covered if medically necessary.

Hemodialysis: Removal of certain elements from the blood through selective diffusion for treatment of kidney failure.

Home health care: Home health care, when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered.

You should call your Network/Claim Administrator to be sure home health care is considered medically necessary.

Hospice care: Eligible Expenses medically necessary for the care and treatment of a terminally ill covered person. Expenses in connection with hospice care include both facility and outpatient care. Hospice care is covered when approved by your Network/Claim Administrator.

Inpatient room and board expenses: The PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options cover in-network inpatient hospital expenses based on the negotiated rates with that particular network hospital. If you use an out-of-network hospital under the PPO 750, PPO 1500 or PPO 2500 Options, the Plan will only consider the portion of the billed expense that does not exceed the out-of-network reimbursement rates. If you are covered under the Out-of-Area option, the Plan will only consider the portion of the billed expense that does not exceed usual and prevailing fees.

Intensive care, coronary care, or special care units (including isolation units): Coverage includes room and board and medically necessary services and supplies.

Mammograms: Medically necessary diagnostic mammograms, regardless of age.

Coverage for routine mammograms for female employees and female dependents is based on the following guidelines:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared
- Once every one to two years from ages 40 to 49 as recommended by your physician
- Once every year beginning at age 50.

Mastectomy: Certain reconstructive and related services are covered following a medically-necessary mastectomy, including:

- Reconstruction of the breast on which a mastectomy was performed
- Surgery or reconstruction of the other breast to produce a symmetrical appearance
- Services in connection with complications resulting from a mastectomy, such as treatment of lymphademas; and
- Prostheses

Medical supplies: Covered medical supplies include, but are not limited to:

- Oxygen, blood, and plasma
- Sterile items including sterile surgical trays, gloves, and dressings
- Needles and syringes
- Colostomy bags
- The initial purchase of eyeglasses or contact lenses required because of cataract surgery

Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.

Multiple surgical procedures: Out-of-network reimbursement for multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage, and to be sure the charges are within the usual and prevailing fee limits or the out-of-network reimbursement rates, contact your Network/Claim Administrator. When you use in-network providers, benefits are based on the negotiated rate with the participating network surgeon.

Newborn nursery care: Hospital expenses for a healthy newborn baby are considered under the baby's coverage, not the mother's.

To enroll your newborn baby in your health benefits, you must process a Life Event change within 30 days of the birth. If you miss the 30-day deadline you will not be able to add your baby to your coverage until the next annual enrollment period, even if you already have other children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby. **Effective January 1, 2017, you will have 30 days from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option.**

You can process most Life Event changes online through the Benefits Service Center.

Nursing care: Coverage includes medically necessary private duty care by a licensed nurse, if it is of a type or nature not normally furnished by hospital floor nurses.

Oral surgery: Hospital charges in connection with oral surgery involving teeth, gums, or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the Medical Benefits Option will pay room and board, anesthesia, and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the Medical Benefits Options. However, they may be covered under the Dental Benefit.

Outpatient surgery: Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, freestanding surgical facility, or physician's office. You should pre-authorize the surgery by contacting your Network/Claim Administrator to ensure the procedure is medically necessary.

Physical or occupational therapy: Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician. Please note that these services are covered in-network. There is no coverage available if you receive these services from an out-of-network provider under the PPO 750, PPO 1500 and PPO 2500 medical options.

Physician's services: Office visits and other medical care, treatment, surgical procedures, and post-operative care for medically necessary diagnosis or treatment of an illness or injury are covered when provided by a physician who is registered, licensed, or certified by the state in which he or she practices. The Medical Benefits Options cover office visits for certain preventive care, as explained under *Preventive Care*.

Pregnancy: Charges in connection with pregnancy, only for female employees and female spouses of male employees. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed, or certified by the state in which he or she practices.

Contact your Network/Claims Administrator to find out about the Maternity Management Program.

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Prescription prenatal vitamin supplements are covered. Federal law prohibits the Plan from limiting your length of stay 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, the Plan 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. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

Charges in connection with pregnancy for covered dependent children are covered only if they are preventive care services based on USPSTF (Grade A & B recommendations) and CDC guidelines or due to certain complications of pregnancy, for example: ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Prescription drugs: Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition.

See "Prescription Drug Benefits" for details of the prescription drug benefit. Prescriptions related to infertility treatment and weight control are not covered. See "Excluded Expenses" for additional information regarding drugs that are excluded from coverage.

Medically necessary medications are also covered for the following special situations:

- Medications administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit unless the medication is a specialty medication only covered under the Prescription Drug benefit. Contact your Network/Claims

administrator or Express Scripts to determine if the medication is covered under your medical option.

- Medications which are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital, or similar institution which operates an on-premises pharmacy are covered as part of the facility's ancillary charges.

Certain types of medicines and drugs that are not covered by the medical benefits may be reimbursed under the Health Care Flexible Spending Accounts (HCFSAs) (see the *Health Care FSA* section).

- **Preventive care:** The Plan covers preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages. Non-routine tests for certification, sports or insurance are not covered unless Medically Necessary.

- The Plan is a non-grandfathered group health plans that complies with the PPACA preventive care requirements.
- Preventive care focuses on evaluating your current health status when you are symptom free.
- Preventive services include those performed on a person who:
    - has not had a preventive screening done before and does not have symptoms or other a documented related existing care related to the outcomes of the screening
    - has had diagnostic screenings that were normal after which your Physician recommends future preventive screening
    - has a preventive service done that results in a therapeutic service done at the same time (e.g. polyp removal during a preventive colonoscopy)
- The Company follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. To get a full list of In-Network preventive care covered at no cost to you visit, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm or https://www.healthcare.gov/preventive-care-benefits/
- Some preventive services have age and frequency limitations. These limitations can be based on Medical Necessity, medical review boards of the carriers in which we partner with to provide health care services and PPACA. Call your Network/Claim Administrator for details on coverage.
- If you receive preventive care at any location other than a Physician's office such as Urgent Care or emergency room, or from an Out-of-Network Provider, services may not be covered at 100%.
- Your health care Provider determines how you are billed for all health plan expenses. When a service is performed for the purpose of preventive screening and is appropriately billed as such by your Provider, then it will be covered under preventive services.

Non-routine tests for certification, sports, or insurance are not covered unless medically necessary. Preventive care will not be covered out-of network under any of the Medical Options, except the Out-of-Area Option.

Prostheses: Prostheses (such as a leg, foot, arm, hand, or breast) necessary because of illness, injury, or surgery. Replacement of prosthesis is only covered when medically necessary because of a change

in the patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.

Radiology (x-ray) and laboratory expenses: Examination and treatment by x-ray, radium, or other radioactive substances, imaging/scanning (MRI, PET, CAT, and ultrasound), diagnostic laboratory tests, and routine mammography screenings for women (see Mammograms for guidelines). Please note that under the PPO 750 Option, your network coverage depends on whether the care is received in a hospital-based setting or a physician's office or independent non-hospital laboratory facility. If you are covered under the PPO 750 Option, and you receive radiology or laboratory services in a network physician's office, a network non-hospital imaging center, or a network non-hospital laboratory, the Plan will cover these expenses at 100% if medically necessary. Receiving radiology and/or laboratory services at a hospital will most likely cost you the most, as these services will be subject to the deductible and coinsurance. Check with the provider and ask if they bill as outpatient hospital facility or as a free-standing non-hospital facility. There are some providers who may appear as an independent facility but are actually owned by a hospital and bill as if the service was performed in a hospital.

If your physician has ordered an MRI, CAT or PET scan for non-emergent services, you must call BCBS of Texas and obtain cost information before you have the procedure performed. If you do not call for cost information prior to your procedure, you will be responsible for an additional $100 .

Reconstructive surgery: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.

Under the Women's Health and Cancer Rights Act, covered reconstructive services include:

- Reconstruction of the breast on which a mastectomy was performed
- Surgery or reconstruction of the other breast to produce a symmetrical appearance
- Services in connection with other complications resulting from a mastectomy, such as treatment of lymphademas; and
- Prostheses.

Speech therapy: Restorative and rehabilitative care and treatment for loss or impairment of speech when the treatment is medically necessary because of an illness (other than a mental, psychoneurotic, or personality disorder), injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy.

Out of Network Services are not covered under the plan.

Surgery: When medically necessary and performed in a hospital, free-standing surgical facility, or physician's office. (See "Prior Authorization" for details about hospital pre-authorization and pre-determination of benefits.)

TeleHealth (effective January 1, 2017): Telehealth services provided by Doctor on Demand will be covered effective January 1, 2017 for minor medical illness or injury, or general medical services.

Temporomandibular joint dysfunction (TMJD): Eligible Expenses under the medical benefits include only the following, if medically necessary:

- Injection of the joints
- Bone resection
- Application of splints, arch bars, or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion
- Manipulation or heat therapy.
- Crowns, bridges, or orthodontic procedures for treatment of TMJD are not covered.

Transplants: Expenses for transplants or replacement of tissue or organs if they are medically necessary and not experimental, investigational, or unproven services. Benefits are payable for natural or artificial replacement materials or devices.

Donor and recipient coverage is as follows:

- If the donor and recipient are both covered under the Plan, expenses for both individuals are covered by the Plan
- If the donor is not covered under the Plan and the recipient is covered, the donor's expenses are covered to the extent they are not covered under any other medical plan, and only if they are submitted as part of the recipient's claim.
- If the donor is covered under the Plan but the recipient is not covered under the Plan, no expenses are covered for the donor or the recipient

The total benefit paid under this Plan for the donor's and recipient's expenses will not be more than any Plan maximums applicable to the recipient.

You may arrange to have the transplant at a network transplant facility rather than a local network hospital. Although using a network transplant facility is not required, these centers specialize in transplant surgery and may have the most experience, the leading techniques, and a highly qualified staff.

It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria—not all transplant situations will be eligible for benefits. Therefore, you **must** contact your Network/Claim Administrator as soon as possible for pre-authorization **before** contemplating or undergoing a proposed transplant. The following transplants are covered if they are medically necessary for the diagnosed condition and are not experimental, investigational, unproven, or otherwise excluded from coverage under the Medical Benefits Options, as determined in the sole discretion of the Plan Administrator and its delegate, the claims processor:

- Artery or vein
- Bone
- Bone Marrow or stem cell
- Cornea
- Heart
- Heart and Lung
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataract surgery
- Intestine

- Kidney
- Kidney and Pancreas
- Liver
- Liver and Kidney
- Liver and Intestine
- Pancreas
- Pancreatic islet cell (allogeneic or autologous)
- Prosthetic bypass or replacement vessels
- Skin

Transportation expenses: Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. For information on ambulance services, see Ambulance in this section.

Tubal ligation and vasectomy: These procedures are covered; however, reversal of these procedures is not covered.

Urgent care: Charges for services and supplies provided at an urgent care clinic are covered. You should contact your network provider or your network/claims administrator for authorization before seeking care at an urgent care clinic, or if you are traveling and need urgent medical care. If your network/claims administrator's office is closed, seek treatment and then call your network/claims administrator within 48 hours to ensure that you receive the network level of benefits. Ask the urgent care center if they are owned by a hospital. Some urgent care centers may appear to be independent of a hospital but are actually owned by a hospital and bill as outpatient hospital.

Well-child care: In-network under the PPO 750, PPO 1500 and PPO 2500, as well as out-of-network under the Out-of-Area Option, children are covered for initial hospitalization following birth, all immunizations, and well-child care visits.

Wigs and hairpieces: Employees and eligible dependents are covered up to a $350 lifetime maximum for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery, or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, copayments, coinsurance, and out-of-pocket limits of the selected Medical Benefits Option.

Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo, and accessories are also excluded.

Mental Health and Chemical Dependency Benefits

Mental Health Care

Covered expenses include medically necessary inpatient care (in a psychiatric hospital, acute care hospital, or an alternative mental health care center) and outpatient care for a mental health disorder.

Inpatient mental health care: When you are hospitalized in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses (see inpatient room and board expenses under "Covered Expenses").

Alternative mental health care center – residential treatment: Coverage for an alternative mental health care center is covered under the Plan when the care is medically necessary.

Alternative mental health care center – intensive outpatient and partial hospitalization: This type of care is covered when medically necessary. Contact your network claims administrator for more information.

Outpatient mental health care: Medically necessary outpatient mental health care is covered as any other illness.

Chemical Dependency Care

Chemical dependency rehabilitation: Covered chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient, or a combination. The Plan does not cover expenses for a family member to accompany the patient being treated, although many chemical dependency treatment centers include family care at no additional cost.

Detoxification: Chemical dependency rehabilitation does not include detoxification. However, the following provisions apply:

- You must call your network/claims administrator for approval of detoxification.
- To receive the network benefit level, detoxification treatment must be approved by your network/claims administrator within 48 hours of admission for detoxification.
- If you do not receive your Network/Claims Administrator approval for detoxification, coverage is provided at the out-of-network benefit level, even if you use a network facility.

Prescription Drug Benefits

The prescription drug program is administered by Express Scripts. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Mail Service prescription drug option.

For information on drugs that are covered, see "Covered Expenses." For drugs that are excluded, refer to "Excluded Expenses."

Prescription drug coverage under an HMO is administered by the individual HMO.

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

Retail Drug Coverage

As a medical plan participant, you may have your prescriptions filled at any pharmacy. However, if you present your Express Scripts ID card at a network pharmacy, you will have access to negotiated discount prices. Express Scripts' broad retail pharmacy network includes more than 65,000 pharmacies. When you fill prescriptions, you are encouraged to use a preferred pharmacy. A preferred pharmacy includes those within the Express Advantage Network, a subset of your broader network, featuring major chain and independent pharmacies, grocery stores, and mass merchants. Non-preferred pharmacies include those retail pharmacies within your broader network but outside of the Express Advantage Network. Filling your prescriptions at a non-preferred pharmacy (e.g.,

Walgreens or CVS) will result in an additional $5 copayment, on top of your copay/coinsurance referenced in the table below. To request a list of participating pharmacy chains in the broader network as well as the Express Advantage Network, call Express Scripts at 1-866-544-2994 or visit the Express Scripts website.

There are three categories of covered drugs with three different co-payments: generic drugs, preferred brand-name drugs and non-preferred brand-name drugs. You will pay the lowest co-payment/coinsurance for generic drugs.

A "formulary" is a preferred list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent committee of physicians and pharmacies brought together by Express Scripts updates this list regularly based on continuous evaluation of medications. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist.

If you are taking a non-preferred drug, you have a choice – you can pay the higher co-payment for it or you can talk with your doctor about the possibility of switching to a generic or preferred brand-name drug.

Contact Express Scripts at 1-866-544-2994 to determine if the brand-name drug you are taking is on the formulary list/preferred. You can also locate this information on the Express Scripts website.

Pharmacy deductibles: If you are enrolled in the PPO 750 or Out-of-Area Options, each covered individual will have to meet a $50 calendar year deductible for prescriptions purchased at retail pharmacies. This $50 deductible is in addition to your medical deductible. If you are covered under the PPO 1500 or PPO 2500 Options, your medical deductible also applies to pharmacy purchases at retail and mail. However, certain preventive medications will bypass the deductible under the PPO 1500 and PPO 2500 Options. Contact Express Scripts to determine if your medication is considered preventive.

The amounts you pay reflected in the chart below are after satisfaction of the deductible. If your deductible has not been satisfied, the amount you pay to purchase prescription drugs will the Express Scripts negotiated/contract price. Please be sure to show your Express Scripts Prescription ID card to the pharmacy to ensure you pay the negotiated amount, and to make sure the amount you pay is counted towards satisfaction of your deductible and out-of-pocket maximum.

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Generic Drug	You pay 20%, with a minimum of $10 and a maximum of $50 per prescription (an additional $5 copay will apply if using a non-preferred network pharmacy)	You pay 20% for a 90-day supply, with a minimum of $25 and a maximum of $125 per prescription

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Formulary Brand Drug	You pay 30%, with a minimum of $35 and a maximum of $100 per prescription (an additional $5 copay will apply if using a non-preferred network pharmacy)	You pay 30% for a 90-day supply, with a minimum of $75 and a maximum of $200 per prescription
Non-Formulary Brand Drug	You pay 50%, with a minimum of $50 and a maximum of $125 per prescription (an additional $5 copay will apply if using a non-preferred network pharmacy)	You pay 50% for a 90-day supply, with a minimum of $125 and a maximum of $275 per prescription

If the actual cost of your prescription is less than the minimum shown above, then you pay just the actual cost.

If you select a brand-name drug when a generic equivalent is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices. Maximums do not apply, unless the drug is required for preventive care and your health care Provider determines that a generic would be medically inappropriate**.**

** Oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices, unless your health care Provider determines that a generic contraceptive would be medically inappropriate.

Retail Refill Allowance

Coverage is provided for up to three fills of long-term maintenance drugs at retail. Unless you begin using the Express Scripts Pharmacy mail-order service by the fourth fill, you will be responsible for 100% of the discounted cost when you purchase the drug at a retail pharmacy.

Drug Type	If You Use a Retail Pharmacy for Your Initial Maintenance Medication Purchase and Two Refill Rx Purchases…	If You Use a Retail Pharmacy for Refills of Maintenance Medication Beyond the Two Refill Limit…
Generic Drug*	You pay 20%, with a minimum of $10 and a maximum of $50 per prescription (an additional $5 copay will apply if using a non-preferred network pharmacy)	You pay 100%
Preferred Brand Drug	You pay 30%, with a minimum of $35 and a maximum of $100 per prescription (an additional $5 copay will apply if using a non-preferred network pharmacy)	You pay 100%
Non-Preferred Brand Drug	You pay 50%, with a minimum of $50 and a maximum of $125 per prescription (an additional $5 copay will apply if using a non-preferred network pharmacy)	You pay 100%

** Oral contraceptives, transdermal and intravaginal contraceptives are covered by mail only at 100% with no co-pay or co-insurance. If a brand contraceptive has a generic equivalent, you will be responsible for the cost difference between the generic and brand prices, unless the drug is required for preventive care and your health care Provider determines that a generic would be medically inappropriate. **If you select a brand-name drug when a generic equivalent is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices,** unless your health care Provider determines that a generic would be medically inappropriate**. Maximums do not apply.**

Filling Prescriptions

Follow these steps to fill prescriptions at a network pharmacy:

- Present your Express Scripts ID card to the pharmacy and pay the appropriate copay/coinsurance.
- Follow these steps to fill prescriptions at an out-of-network pharmacy:
- Pay the full retail price (undiscounted) for the prescription and obtain a receipt when you pick up your prescription.

File a claim for reimbursement with Express Scripts. Express Scripts will reimburse the patient based on the discounted cost of the medication minus the applicable copay/coinsurance. Reimbursement will be accompanied by an EOB.

If you elected to participate in the Health Care Flexible Spending Account (see the *Health Care FSA* section), your retail drug out-of-pocket expense is eligible for reimbursement.

If you have questions concerning this program, call the Express Scripts Member Services number on your Express Scripts ID card. If you have questions about the benefit amount paid, call your network/claims administrator.

Claim Filing Deadline

You must submit all claims, including prescription drug claims, within one year of the date expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

Prior Authorization

To be eligible for benefits, certain covered prescriptions require prior authorization by Express Scripts to determine medical necessity before you can obtain them at a participating pharmacy or through the mail service option.

When you fill your prescription, Express Scripts will send a message instructing your pharmacist to call Express Scripts. A Express Scripts pharmacist will then contact your physician to review the request for approval. Express Scripts sends both you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for the original approved time up to one year. In the event a pharmacy does not fill a prescription, the pharmacy's denial shall not be treated as a claim for benefits, instead you must file a claim with the Claims Administrator for the medication to initiate the benefit claim and appeal procedures under the medical benefits option.

Prior authorizations expire and must be renewed. You will receive the expiration date with your approval and a reminder 30 days prior to the expiration date with instructions on how to renew.

To request prior authorization, ask your physician's office to initiate the Prior Authorization by calling the PA hotline 1-800-753-2851. Express Scripts will fax the required prior authorization criteria to your physician.

Express Scripts will advise you whether your prior authorization is approved or denied. If it is denied, they will explain the reason for denial.

Specialty Pharmacy Services

Specialty pharmacy services are services dedicated to providing a broad spectrum of outpatient prescription medicines and integrated clinical services to patients on long-term therapies which support the treatment of complex and chronic diseases.

Accredo Health Group, a subsidiary of Express Scripts, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications.

Prescriptions prescribed to manage the following medical conditions must be filled at one of Accredo's Health Group pharmacies through Express Scripts:

- Anemia/Neutropenia
- Growth Hormone
- Hemophilia
- Hepatitis C
- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs

- Osteoporosis
- Rheumatoid Arthritis and Other Autoimmune Conditions
- Pulmonary / Pulmonary Arterial Hypertension
- Other Various Indications

PLEASE NOTE: Specialty Agents are added as required/appropriate.

Whether these prescriptions are self-administered or administered in a physician office, the prescriptions to treat the above conditions will no longer be reimbursed through your medical plan and must be filled through Accredo by Express Scripts. Express Scripts can ship the prescription to the patient's home for self-administration or to the physician's office for medications which are to be administered by a physician.

The applicable copayment associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions. If you are not sure if your medication is a specialty medication, please contact Express Scripts.

Please note that if you receive any type of manufacturer assistance, where the manufacturer of the medication pays a portion of the cost for you, the amount paid by the manufacturer or any other entity, will not count towards your out-of-pocket maximum. Only amounts paid directly by you will count towards your out-of-pocket maximum under the Plan.

Mail Service Prescription Drug Option

As a participant in the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options, you and your covered dependents are eligible for the Mail Service Prescription Drug Option offered through Express Scripts (formerly Medco). You may use the mail service option to order prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease, and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration.

To encourage you to take advantage of the Plan's mail order prescription drug program, you may only get an initial purchase and two refill purchases of a maintenance medication at a retail pharmacy. After that, you should consider filling your remaining maintenance medication prescriptions through the mail order prescription drug program to avoid paying the full cost for refills.

Generic Drugs

Many drugs are available in generic form. Your prescription will be substituted with a generic when available and your physician considers it appropriate. A-rated generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using A-rated generic drugs, you save money for yourself and the Plan. If a brand name drug is not specified, your prescription may be filled with the generic. However, if you elect to fill a prescription with a brand name drug and a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices**,** unless the drug is required for preventive care and your health care Provider determines that a generic would be medically inappropriate.

Ordering Mail Service Prescriptions

Initial order: To place your first order for a prescription through the mail service option, follow these steps:

- Provide the information requested on the back of your mail service order envelope, and complete and enclose the patient profile form found in your initial packet from Express Scripts. (The profile will not be necessary on refills or future orders unless your health changes significantly.)
- Insert the original written prescription signed by your physician.
- If the prescription is for a non-medically necessary oral contraceptive, or you elect to take a brand name drug when a generic is available (unless your health care Provider determines that a generic contraceptive would be medically inappropriate), call Express Scripts or visit the Express Scripts website to find out how much you must pay for the prescription.
- Indicate the desired method of payment on the mail service order envelope. You may charge your payment to a major credit card (MasterCard, VISA, or Discover) or pay by personal check or money order. If paying by check or money order, enclose your payment with the order. Do not send cash. You may also pay for your prescriptions by entering the information for your Health Care Flexible Spending Account card.
- Mail your order to the address on the order envelope

You may request a mail order envelope by contacting Express Scripts at 1-866-544-2994.

Internet Refill Option

The Internet gives you access to Express Scripts 24 hours a day, seven days a week. Using Express Scripts online, you can order prescription drug refills, check on the status of your order, request additional forms and envelopes, or locate a network pharmacy near you on the Express Scripts website.

To refill a prescription online, you will simply need to supply your Express Scripts member ID number (Social Security number), the prescription (RX) numbers you want to refill and the method of payment. Verify your address on file and review your order. When you order refills online, you will receive a detailed summary of your order, including costs. Please allow up to 14 days for delivery of your prescription.

Other Refill Options

If you elect not to use the Internet refill option, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call at 1-866-544-2994 to request a refill. They will need your Express Scripts ID number, current mailing address, and Express Scripts Health Rx Services prescription number
- If you prefer to order by mail, complete a mail service order envelope and attach your Express Scripts refill prescription label to the form or write the prescription refill number on the envelope. Include your payment with
  your order.

Maximum Medical Benefits

Express Scripts Rx Services sends you a statement with each prescription they fill. The statement advises you of your copayment, and the amount the Company paid.

Reimbursement of Copayments/Coinsurance

Your mail order copayment/coinsurance for eligible prescription drugs counts towards your out-of-pocket maximum.
If you elected to participate in the Health Care Flexible Spending Account, you may submit your copayment/coinsurance expenses for reimbursement. (See the *Health Care FSA* section for details.)

Excluded Expenses

The following items are excluded from coverage, under all Medical Benefit Options offered under the Plan (excluding HMO coverage), unless otherwise stated. For exclusions under an HMO, check with the HMO directly.

Allergy testing: Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

Alternative and/or complementary medicine: Evaluation, testing, treatment, therapy, care and medicines that constitute alternative or complementary medicine, including but not limited to herbal, holistic, and homeopathic medicine.

Bariatric surgeries: Bariatric surgeries (including but not limited to Gastric bypass, LAP Band, etc.) will not be covered out-of-network.

Claim forms: The Plan will not pay the cost for anyone to complete your claim form.

Care not medically necessary: All services and supplies considered not medically necessary.

Cosmetic treatment:

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction, and sclerotherapy for varicose veins or spider veins)
- Cosmetic surgery, unless medically necessary and required as a result of accidental injury or surgical removal of diseased tissue

Counseling: All forms of marriage and family counseling

Custodial care and custodial care items: Custodial care and items such as incontinence briefs, liners, diapers, and other items when used for custodial purposes, unless provided during an *inpatient* confinement in a hospital or convalescent or skilled nursing facility.

Developmental therapy for children: Charges for all types of developmental therapy. Certain therapies for the diagnosis of autism may be covered. Please contact your Network/Claims administrator for more information.

Dietician services: Dietician services are covered only under the PPO 750 Option and only if you are using network providers. Contact your network/claims administrator or your network provider to determine what services are covered. All other dietician services are excluded.

Drugs:

- Drugs, medicines, and supplies that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets, and test tape.)
- Drugs which are not required to bear the legend "Caution-Federal Law Prohibits Dispensing Without Prescription"
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
- Contraceptive drugs, patches, or implants when not purchased through the Express Scripts Mail Order Pharmacy (See "Mail Service Prescription Drug Option" under "Prescription Drug Benefits").
- Drugs requiring a prescription under state law, but not federal law
- Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy)
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Medications used primarily for the purpose of weight control
- Drugs used to treat infertility, or to promote fertility
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the Food and Drug Administration (FDA), or experimental drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis.

Ecological and environmental medicine: See Alternative and/or Complementary Medicine

Educational testing or training: Testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities) is excluded

Experimental, investigational, or unproven treatment: Medical treatment, procedures, drugs, devices, or supplies that are generally regarded as experimental, investigational, or unproven, including, but not limited to:

- Treatment for Epstein-Barr Syndrome
- Hormone pellet insertion
- Plasmapheresis

See the Experimental, Investigational or Unproven treatment definitions in the Glossary.

Eye care: Eye exams, refractions, eye glasses or the fitting of eye glasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training, and vision therapy.

Foot care: Diagnosis and treatment of weak, strained, or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses, or toenails. (This exclusion does not apply to the removal of nail roots.)

Free care or treatment: Care, treatment, services, or supplies for which payment is not legally required.

Government-paid care: Care, treatment, services, or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

Infertility treatment: Expenses or charges for infertility treatment *or* testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.

Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer, and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction, and infertility drugs such as, for example, Clomid or Pergonal, are also excluded.

Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

Lenses: No lenses are covered except the first pair of medically necessary contact lenses or eye glasses following
cataract surgery.

Massage therapy: All forms of massage and soft-tissue therapy, regardless of who performs the service.

Medical error events: Services or supplies charged by the health care provider that are directly associated with, resulting from, or caused by medical mistakes, medical or surgical error or complication, medical negligence or malpractice, preventable illness, preventable injury, or certain preventable complications arising from medical or surgical treatment, as defined by the Center for Medicare and Medicaid Services and identified as "never events." For more information on what comprises these events, go to http://www.cms.gov/ >Site Tools & Resources>Media Release Database. There you'll find fact sheets and news releases about these "never events."

Medical records: Charges for requests or production of medical records.

Missed appointments: If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.

Nursing care:

- Care, treatment, services, or supplies received from a nurse that do not require the skill and training of a nurse
- Private duty nursing care that is not medically necessary, or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses
- Certified nurses' aides.

Organ donation: Expenses incurred as an organ donor, when the recipient is not covered under the Plan.

Pregnancy for dependents: Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Relatives: Coverage is not provided for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist, or speech therapist) who is a close relative (spouse, child, brother, sister, parent, or grandparent of you or your spouse, including adopted and step relatives).

Sleep disorders: Treatment of sleep disorders, unless it is considered medically necessary.

Sex changes: Sex change, gender reassignment/revision, treatments or transsexual and related operations.

Sexual performance treatment: Prescription medications (including but not limited to, Viagra, Levitra, or Cialis), procedures, devices, or other treatments prescribed, administered, or recommended to treat erectile dysfunction or other sexual dysfunction, or for the purpose of producing, restoring, or enhancing sexual performance/experience.

Speech therapy: Except as described in "Covered Expenses," expenses are not covered for losses or impairments caused by mental, psychoneurotic, or personality disorders or for conditions such as learning disabilities, developmental disorders, or progressive loss due to old age. Speech therapy of an educational nature is not covered. Speech therapy is not covered if provided by an out-of-network provider unless you are covered under the Out-of-Area option.

TMJD: Except as described in "Covered Expenses," diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD), or syndrome by a similar name, including orthodontia to treat TMJD. Crowns, bridges, or orthodontic procedures to treat TMJD are not covered.

Transportation: Transportation by regularly scheduled airline, air ambulance, or train for more than one round trip per illness or injury.

Usual and prevailing: Any portion of fees for physicians, hospitals, and other providers that exceeds the *usual and prevailing fee limits*. (Applies to out-of-network providers.)

War-related: Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.

Weight reduction: Hospitalization, surgery, treatment, and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact your Network/Claim Administrator (or HMO if applicable) to determine if treatment is covered.

Wellness items: Items that promote well-being and are not medical in nature, and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas, and health club memberships). Also excluded are:

- Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing, and work hardening programs

Contact your Network/Claims Administrator (or HMO, if applicable) to determine if your option covers a specific preventive service for a particular medical condition.

Work-related: Medical services and supplies for treatment of any work-related injury or illness sustained by you or your covered dependent, whether or not it is covered by Workers' Compensation, occupational disease law, or other similar law.

Filing Claims

Your network/claims administrator is the claims processor for the PPO 750, PPO 1500, PPO 2500 and the Out-of-Area Options. Your network/claims administrator provides claim services; however, they do not insure the health benefits. Benefits for these Medical Benefits Options are self-funded, which means that all claims are paid from the Company's general assets. Contributions also may be required by employees, in an amount determined by the Company in its discretion.

Regardless of which Medical Benefits Option you are enrolled in, if you received services from an in-network/Medical Discount Program PPO provider, your provider will generally file the claim for you. If you use a non-network provider or for any reason you must file the claim yourself, follow the procedures below:

- Complete a Medical Benefit Claim Form (instructions are provided on the form)
- Submit the completed form to your network/claims administrator, along with all itemized receipts (originals) from your physician or other health care provider. A cancelled check is not acceptable.

Each bill or receipt submitted to your network/claims administrator must include the following:

- Name of patient
- Date the treatment or service was provided
- Diagnosis of the injury or illness for which treatment or service was given
- Itemized charges for the treatment or service
- Provider's name, address, and tax ID number

Be sure to make copies of the original itemized bill or receipt provided by your physician, hospital, or other medical service provider for your own records. Photocopies are not accepted by your network/claims administrator.

All medical claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid.

It is very important that you fully complete the sections of the form regarding other possible coverage. Examples of other possible coverage include a spouse's group health plan, Workers' Compensation, Medicare, Champus and no-fault motor vehicle insurance.

If you have questions about your coverage or your claim, contact your network/claims administrator or Express Scripts.

Claims Filing Deadline

You must submit all claims, including prescription drug claims, within one year of the date expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

The full claims procedure is described in detail under "Claims" in the *Plan Administration* section.

Employee Assistance Program (EAP)

The Company recognizes that alcohol and drug dependency and other serious personal problems affect an employee's health and job performance. The Employee Assistance Program (EAP) helps employees obtain treatment for these problems before health, safety, and work performance are compromised. The EAP is available to all employees and their dependents at no cost.

The EAP protects confidentiality. Contacting the EAP for assistance does not jeopardize job security and advancement opportunities. However, the Company will not knowingly allow employees to work if there is a question concerning fitness for duty. In addition, EAP participation does not relieve an employee of the obligation to comply with Company rules and regulations.

You may contact the EAP by calling 1-866-312-5018. The EAP can help you find solutions to a full range of personal concerns. No problem is too big or small. These can include:

- Stress
- Crisis
- Marital and family problems
- Emotional concerns
- Relationship issues
- Child care referrals
- Psychiatric Disorders
- Alcohol or Drug problems
- Debt and financial problems

The EAP offers extensive online resources to help with most any of life's common issues and concerns. You may obtain expert advice on a wide range of topics, gather information and resources, take self-screenings, or just learn more about the EAP's offerings. To access the EAP website, go to www.eapconsultants.com and sign in. Your password is envoyeap. You can also log in at my.envoyair.com and type EAP in the search bar.

The Legal Plan Benefit

The **Hyatt Legal Plan** covers you, your spouse and dependents. This plan is insured and administered by Hyatt Legal, which is owned by Metlaw.

The legal plan benefit offers t**elephone and office consultation** along with online services for an unlimited number of personal legal matters with a network attorney of your choice.

Legal Plan services include:

- Estate Planning
- Document Review
- Family Law
- Immigration Assistance
- Elder Law Matters
- Real Estate Matters
- Document Preparation
- Traffic Offenses
- Personal Property Protection
- Financial Matters
- Juvenile Matters
- Defense of Civil Lawsuits
- Consumer Protection
- Family Matters
- Will Preparation

You may enroll in legal plan coverage during the annual enrollment period each year. Your election stays in effect for the entire calendar year. You may access legal services while covered under the Plan as many times as needed during the calendar year of your coverage. In most cases, you do not pay for these services when they are rendered.

Critical Illness Benefit

When you and your dependents elect to participate in critical illness insurance, you receive benefits in the form of direct lump-sum payments that can be used to help pay for expenses related to covered illnesses and diseases. Covered illnesses and diseases include invasive cancer, carcinoma in situ, heart attack, stroke, coronary artery bypass surgery, end-stage renal failure, Alzheimer's disease, and many others.

Dependent Eligibility

Coverage may include you, your Spouse, including Domestic Partner, and children under age 26. **Effective January 1, 2017, Domestic Partners will no longer be eligible for coverage under the Plan.**

Critical Illness Benefit
Benefits are payable if you are diagnosed with one of the conditions listed below.

The following benefits are payable at 100% of your coverage election. Covered children receive 50% of your benefit amount:

- Heart attack
- Stroke
- Coronary artery bypass surgery
- Major organ transplant
- End stage renal failure
- Invasive Cancer
- Carcinoma in Situ
- Benign Brain Tumor
- Alzheimer's Disease
- Coma
- Named diseases

Additional benefits:
- Lump sum recurrence
    - Benefits will be paid at 100% of the First Occurrence Benefit for a recurrence of the same condition. Benefits will be paid as a percentage of elected coverage for a recurrence when the events are separated by a minimum of 12 months (12 months

treatment-free for cancer). The same condition is included except for incurable diseases.

- Non-Invasive Skin Cancer
- Transportation
  - Transportation of a covered person for the round trip distance between hospital, medical facility and residence of covered person; excludes hospitals within 100-mile radius; annual maximum of $5,000.
- Lodging
  - Not payable for more than 24 hours prior to or following treatment; outpatient treatment must be more than 100 miles from residence; annual maximum of $3,600 and 60 days/calendar year.
- National Cancer Institute Evacuation
  - Includes coverage for evaluation/consultation and transportation/lodging if cancer center is more than 100 miles from residence.

Your Certificate of Insurance will contain complete information on the benefits payable through this coverage. To obtain a copy, visit Allstatebenefits.com/mybenefits

Exclusions and Limitations –

- Allstate Benefits does not pay benefits for: (a) any act of war, whether or not declared, during military service; (b) active participation in a riot, civil disorder, insurrection, or rebellion; (c) intentionally self-inflicted injuries; (d) engaging in an illegal occupation or committing or attempting to commit a felony; (e) attempted suicide, while sane or insane; (f) injury sustained while under the influence of narcotics or any controlled chemical substance unless administered upon the advice of a physician; (g) participation in aeronautics except as a fare-paying passenger in a licensed common-carrier aircraft; (h) alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.
- Stroke Exclusions – Transient ischemic attacks (TIAs), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded.
- Coronary Artery Bypass Surgery Exclusions – The following procedures are not considered coronary artery bypass surgery: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.
- Alzheimer’s Disease and Parkinson’s Disease Limitation – Must be diagnosed by a psychiatrist or neurologist and the insured must be unable to perform at least 3 activities of daily living*.

  *Activities of daily living are: bathing, dressing, toileting, eating, and taking medication.
- **Carcinoma in Situ Exclusions** – Does not include: other skin malignancies; premalignant lesions (such as intraepithelial neoplasia); or benign tumors or polyps.
- **Invasive Cancer Exclusions** – Does not include: carcinoma in situ; tumors related to HIV; non-invasive or metastasized skin cancer; or early prostate cancer.

When your critical illness insurance coverage begins

If you enroll during annual enrollment, your coverage will become effective on the first day of the Plan year related to annual enrollment.

If you enroll outside of annual enrollment, your coverage will become effective on the date of your status change event or the end of your eligibility waiting period, whichever is later. If you should die before your effective date (as indicated above), no critical illness insurance benefit will be paid to your beneficiary(ies).

Your critical illness insurance will begin whether or not you are actively-at-work, as long as you have reported for your first day of work and enrolled for the benefit.

Filing a claim

Within 60 days of the occurrence or commencement of any covered critical illness, or as soon as reasonably possible, send a notice of claim to:

American Heritage Life Insurance Company

P.O. Box 43067

Jacksonville, FL 32203-3067

Be sure to provide the following information for the covered person:

- Name;
- Social security number; and
- Date the covered illness occurred or commenced.

You may request a claim form from Allstate Benefits or visit Allstatebenefits.com/mybenefitsto obtain an online copy. If you don't receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Claims will be determined under the time frames and requirements set out in the Claims and Appeals section. You or your beneficiary has the right to appeal a claim denial. See the Claims and Appeals section for details.

Naming a beneficiary

If a covered person dies, the covered person's beneficiary(ies) will receive the benefits due at the time of the covered person's death.

You must name a beneficiary(ies) to receive your critical illness insurance benefit if you die. You may do this by going to Allstatebenefits.com/mybenefits.

You can name anyone you wish. If the beneficiaries you have listed with the Plan differ from those named in your will, the list that the Plan has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name;
- Beneficiary(ies) current address;
- Beneficiary(ies) phone number;
- Beneficiary(ies) relationship to you;
- Beneficiary(ies) Social Security number;
- Beneficiary(ies) date of birth; and
- The percentage you wish to designate per beneficiary up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiaries unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney before naming a minor as a beneficiary.

It's important to keep your beneficiary information up to date. Proceeds will go to whomever is listed on your beneficiary form on file with the Plan, regardless of your current relationship with that person, unless state law requires otherwise.

You are automatically assigned as the primary beneficiary of your dependent's critical illness coverage. If you and your dependent(s) die at the same time, benefits will be paid to your dependent's estate or at Allstate Benefits' option to a surviving relative of the dependent.

Changing Your Beneficiary

You beneficiary(ies) can be changed at any time on the Benefits Service Center (Aon Hewitt) website which can be accessed from my.envoyair.com. Any change in beneficiary must be completed and submitted to the Plan before the covered person's death.

If You Do Not Name a Beneficiary

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

1. Your spouse/partner; if not surviving, then
2. Your children, in equal shares; if not surviving, then
3. Your parents, in equal shares; if not surviving, then
4. Your siblings, in equal shares; if not surviving, then
5. Your estate.

When Benefits Are Not Paid

The policy does not pay benefits for any critical illness due to or resulting from (directly or indirectly):

- Any act of war, whether or not declared, or participation in a riot, insurrection, or rebellion;
- Intentionally self-inflicted injuries;
- Engaging in an illegal occupation or committing or attempting to commit a felony;
- Attempted suicide, while sane or insane;
- Being under the influence of narcotics or any other controlled chemical substance, unless administered upon the advice of a physician;
- Participating in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
- Alcohol abuse or alcoholism, drug addiction, or dependence upon any controlled substance.

If You Go on a Leave of Absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave.

Break in Coverage

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you were on a leave) and you return to actively-at-work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you were on a leave) and you return to actively-at-work status after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period under the conditions prescribed by the Plan by contacting the Benefits Service Center.

When Coverage Ends

Your critical illness insurance coverage ends on the earliest of the following:

- The last day of active employment;
- Upon failure to pay your premiums;
- The date the maximum total percentage of the basic benefit amount is paid; or
- When the benefit is no longer offered by the company.

Your critical illness insurance coverage for your Spouse/Domestic Partner ends:

- On the last day of the pay period when your job status changes to part-time;
- Upon a valid decree of divorce;
- Upon termination of your domestic partnership or; or
- Upon your death.

Your critical illness insurance coverage for your dependent children ends:

- When the child reaches age 26;
- When the child does not meet the requirements of an eligible dependent.

Continuation of Coverage at Termination

If your coverage under critical illness insurance terminates as described earlier in this section, you may continue to receive critical illness insurance directly from Allstate Benefits through portability coverage. To receive portability coverage, you must notify Allstate Benefits that you wish to receive portability coverage and send the first premium for such coverage within 60 days of the date your coverage under critical illness insurance terminated.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums will be at the same rate that is in effect under critical illness insurance for active employees with the same coverage.

For more information, please contact Allstate Benefits at 1-800-521-3535.

When Your Dependent Becomes Ineligible

Any eligible dependent who was covered under critical illness insurance at the time such coverage terminated may also receive portability coverage, under the terms described in the Continuation of Coverage at Termination section above.

For more information, please contact Allstate Benefits at 1-800-521-3535.

Dental Benefits

The Company offers you the opportunity to enroll in the Dental Benefit to help pay for covered dental services. The Dental Benefit is self-funded by the Company and administered by MetLife. ID cards are not necessary under the Dental Benefit. The dental provider's office is responsible for verifying eligibility.

The Dental Benefit offers a Preferred Dentist Program (PDP) — a voluntary network of over 120,000 participating dental locations nationwide that provide fee discounts to plan participants. You are not required to use a network dentist, but you will generally save money when you do. To access a list of network dentists in your area, log on to the MetLife website or call MetLife at 1-800-838-0875.

Key Features of the Dental Benefit

Feature	Dental Benefit	
	In-Network	***Out-of-Network***
Annual Deductible	$75 per person	$75 per person
Preventive Service (Exams, cleanings, maximum 2 visits per year routine x-rays once per year)	100% In-Network Deductible Waived	100% Out-of-Network Deductible Waived
Basic (Sealants, Space Maintainers, Amalgam/Resin Composite Fillings, Pulp Capping, Endodontic, Oral Surgery, Periodontics)	80% In- or Out-of-Network after $75 deductible	
Major Services (Crowns, Bridges, Dentures, Implants)	50% In- or Out-of-Network after $75 deductible	
Orthodontia Services (Eligible dependent children only; no deductible applies)	50% In- or Out-of-Network up to a maximum of $1,500	
Maximum Benefit (Per person per year)	$1,500	
Maximum Lifetime Orthodontia Benefit (Per dependent child)	$1,500	

How the Dental Benefit Option Works

The following is information you need to know about Dental Benefit coverage and circumstances that determine how benefits are paid:

Medically necessary: Only dental services that are medically necessary are covered by the Dental Benefit. Cosmetic services are not covered.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses is based on the usual and prevailing fee limits for that service in that geographic location (unless billed by a PDP dentist). You may be responsible for any amount that is deemed in excess of the usual and prevailing fee for a service.

Pre-determination of benefits: If your dentist estimates that charges for a procedure will be substantial, you should request pre-determination of benefits before you receive treatment. However, it is recommended that you obtain pre-determination for any proposed procedure. To request pre-determination from the claims processor, your dentist may complete the standard Dental Claim Form, indicating that it is for pre-determination of benefits.

Alternative treatment: If you undergo a more expensive treatment or procedure when a less expensive alternative is available, the Dental Benefit pays benefits based on the less expensive procedure that is consistent with generally accepted standards of appropriate dental care.

When expenses are incurred: For purposes of determining Dental Benefit coverage and benefits, the dental expense is deemed to be incurred at the time of the initial treatment or preparation of the tooth.

The Preferred Dentist Program (PDP): The Dental Benefit offers a network of participating dentists nationwide (general dentists and specialists) at locations who provide fee discounts to Dental Benefit participants. You are not required to use PDP network dentists, but will benefit from cost savings when you do. You can request a customized directory of participating dentists in your area by calling MetLife (see “Contact Information” in the *Reference Information* section) or by visiting the MetLife website.

Injury by others: If you are injured by someone else and your dental plan pays a benefit, the Company will recover payment from the third party (see “Subrogation” under “Claims” in the *Plan Administration* section).

Health Care Flexible Spending Account: Dental expenses are eligible for reimbursement and will automatically roll over to your account if you participate in a Health Care Flexible Spending Account, unless you inform your network/claims administrator that you want to discontinue the automatic rollover feature. If you cover a Company-recognized Domestic Partner or a dependent of a Company-recognized Domestic Partner, you must inform the FSA administrator that you want to discontinue the automatic rollover feature. See “Eligible Expenses” in the *Health Care FSA* section for important details.)

Coordination of benefits: If you or a covered dependent has coverage under any other group dental plan, the Dental Benefit coordinates benefits with the other plan. (See “Coordination of Benefits” in the *Additional Health Benefit Rules* section for additional information.)

Covered Expenses

To be covered by the Dental Benefit Option, a dental expense must be medically necessary and provided by a duly qualified and licensed dentist or physician (unless specifically excluded). Charges for covered items must be within the usual and prevailing fee limits. The following dental services and supplies are covered by the Dental Benefit:

Dentures and bridgework: Full and partial dentures and fixed bridgework, including:

- Installation of the initial appliance to replace natural teeth extracted, including adjustments within six months of installation
- Replacement if the appliance is more than five years old and cannot be repaired (Appliances that are over five years old but can be made serviceable will be repaired, not replaced)
- Installation of the appliance for teeth missing as a result of a congenital anomaly. (Charges are limited to the allowance for a standard prosthetic device.)

The total allowance for both a temporary and permanent denture or bridge is limited to the maximum benefit for a permanent denture or bridge. Charges are determined from the date the first impression is taken.

Extractions, necessary surgery, and related anesthetics: These services are considered covered dental treatments. However, fractures and dislocations of the jaw are included under Medical Benefit Options.

Fillings and crowns: Composite, silver (amalgam) or porcelain fillings and plastic restorations subject to the following:

- Porcelain crowns are covered only for the 10 front upper and 10 front lower teeth
- Porcelain or plastic facings on crowns posterior to the second bicuspid are not covered
- Gold fillings and crowns are covered only when the tooth cannot be restored with other materials
- Crowns may only be replaced if the existing crown is more than five years old, regardless of the reason for the replacement.

Implants: Dental implants, inlays, and onlays only if medically necessary and approved by independent dental consultants selected by the Company are covered at 50%.

Night guards: Also referred to as occlusal guards and bruxism appliances are covered at 50% one per two year period.

Oral examinations, x-rays, and laboratory tests: The following are covered if necessary to determine dental treatment:

- Full mouth x-ray once in any five-year period
- Adult Bitewing x-ray one per calendar year
- Other x-rays necessary to propose diagnosis or examine progress of treatment.

Periodontal treatment: Medically necessary periodontal treatment of the gums and supporting structures of the teeth and related anesthetics with the frequency of treatment based on generally accepted standards of good periodontal care.

Preventive treatment:

- Exams twice per calendar year
- Routine x-rays once per calendar year
- Teeth cleaning twice per calendar year
- Fluoride treatments twice a year for children under age 14. For children over 14 and adults fluoride treatments are allowed once a year.
- Sealants for children under age 15 (not covered on or after the child's 15th birthday)
- Space maintainers.

Root canals: Root canals and other endodontic treatments are covered. The charge for root canal therapy is considered to have been incurred on the date the tooth is opened.

Covered Orthodontia Expenses

The dental plan covers orthodontic treatment for an eligible dependent child only and covers 50% of eligible and necessary expenses, to a maximum orthodontia benefit of $1,500 during the entire time the child is covered by the Plan. Orthodontic coverage includes examinations, x-rays, laboratory tests,

and other necessary treatments and appliances. There is no deductible for orthodontic treatments, and payments for orthodontia do not reduce the annual maximum benefit for other services.

The following explains additional information about orthodontia coverage:

Ongoing dental coverage: To remain eligible for coverage of orthodontic treatments that extend into a new coverage period (for example, the next calendar year), you must continue to cover the patient under your dental option during each annual enrollment period.

Payment of claims: Payment for orthodontia is made according to the following procedures (regardless of the payment method you arrange with your provider):

- The provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment — even if the duration of treatment moves across calendar years. The Dental Benefit will pay up to the maximum orthodontia benefit of $1,500, in one lump sum, based upon the orthodontist's lump sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit).
- Coordination of benefits applies if the patient has other orthodontia coverage. If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the $1,500 maximum orthodontia benefit.

Health Care Flexible Spending Account

If you participate in the Health Care Flexible Spending Account (HCFSA), the your share of the total cost of the patient's orthodontic treatment (based upon the lump sum billing from the orthodontist) will be reimbursed from your HCFSA in one lump sum, up to the amount you elected to contribute for the year. Other dental services are also eligible for reimbursement, as explained in "Eligible Expenses" in the *Health Care FSA* section). The FSA administrator is Aon Hewitt.

Excluded Expenses

The following expenses are not eligible for reimbursement under the Dental Benefit:

Anesthesia: General anesthetics (unless provided for oral surgery or periodontics).

Cosmetic treatment: Treatment or services partly or completely for cosmetic purposes or characterization or personalization of dentures or appliances for specialized techniques.

Crowns or appliances: Crowns, adjustments, or appliances used to splint teeth, increase vertical dimensions, or restore occlusion. Replacement of crowns less than five years old will not be covered, regardless of the reason for replacement.

Education or training: Education, training, or supplies for dietary or nutritional counseling, personal oral hygiene, or dental plaque control.

Free care: Charges for services or supplies that you are not legally required to pay.

Medical expenses: Any charge for dental care or treatment that is an eligible expense under your Medical Benefit Option.

Prescription drugs: Dental prescriptions. (These are covered under the Medical Benefits Options. However, some HMOs do not cover dental prescriptions.)

Relatives: Treatment by a dentist or physician who is a close relative, including your spouse, children, adopted and step relatives, sisters and brothers, parents, and grandparents of you or your spouse.

Replacement dentures or bridges: Replacement charges for full or partial dentures or a fixed bridge that is less than five years old. Appliances that are over five years old but can be made serviceable will be repaired, not replaced. Any charges that exceed the cost of a standard prosthetic appliance.

Services not provided by dentist or physician: Any service not provided by a dentist or physician, unless performed by a licensed dental hygienist under the supervision of a dentist or physician, or for x-ray or laboratory tests ordered by a dentist or physician

Temporary dentures, crowns, or bridges after 12 months: A temporary fixture, such as a temporary denture, crown, or bridge that remains in place for 12 months or more is considered permanent and the cost of replacement is only covered when the item is more than five years old.

Temporomandibular joint dysfunction (TMJD): TMJD is considered an illness and has limited coverage only under the Medical Benefit Options (see *Medical Benefits Overview* for more information).

U. S. government services or supplies: Charges for services or supplies furnished by or for the U. S. government.

Usual and prevailing: Charges that exceed the usual and prevailing fee limits.

War-related: Services or supplies received as a result of a declared or undeclared act of war or armed aggression.

Work-related claims: Dental care received because of a work-related injury or illness sustained by you or your covered dependent, whether or not it is covered under Workers' Compensation, occupational disease law, or similar law.

Filing Claims

MetLife is the claims processor for the Dental Benefit; however, MetLife does not insure these benefits. Benefits for the Dental Benefit are self-funded, which means all claims are paid from the Company's general assets. Contributions also may be required by employees, in an amount determined by the Company in its discretion.

Completing the Dental Claim Form

The following is a summary of how to file claims for dental expense benefits:

- Complete the top portion of the Dental Expense Claim Form. Follow the instructions that accompany the form and then present the form to your dentist, who completes the remaining portion.
- Mail the completed claim form to MetLife at the address on the form.
- All dental claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid. Payments may, however, be sent directly to your dentist or other dental provider if your provider accepts Assignment of. If you assign benefits to the service provider, the EOB will be mailed to you and the payment mailed to your provider.

Claim Filing Deadline

You must submit all dental claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment. Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency under the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

For the complete claims procedures that apply to the Dental Benefit, see the "Claims and Appeals" section.

Additional Rules

The following sections of the *Additional Health Benefit Rules* section apply to the Dental Benefits.

- "Qualified Medical Child Support Order"
- "Coordination of Benefits"
- "Coordination with Medicare"
- "Continuation of Coverage – COBRA Continuation"

Vision Benefits

There are two plans that can help you save money on your vision care.

- EyeMed Vision Insurance Plan
- **EyeMed Vision Discount Plan. The EyeMed Vision Discount Plan will not be offered on or after January 1, 2017**.

EyeMed Vision Discount Plan

You receive an annual EyeMed membership card to present at participating optical stores. Presenting the card at the time of purchase entitles you to discounts on eyeglass lenses, frames, contact lenses, and sundry items. No claim form or special paperwork is required. To find the nearest participating EyeMed optical store, call the toll free number listed on your membership card and ask for the location nearest you. The EyeMed Vision Discount Plan will not be offered on or after January 1, 2017.

EyeMed Vision Insurance Plan

This Vision Insurance Plan is a preferred provider insurance program contracted through EyeMed. EyeMed has a national network of more than 4,000 chain and independent optical stores.

With EyeMed you'll receive savings averaging 37% on lenses and frames, a 20% savings on contact lenses and any sundry items and a 10% savings on disposable contacts. EyeMed preferred pricing limits the amount EyeMed providers can charge for a comprehensive eye examination. The EyeMed preferred pricing cannot be used in conjunction with any other promotion.

Covered Services	You Pay…
Exam	$10 copayment
Frames	**$140 allowance**
Lens	**$25 copayment**
CONTACT LENSES (IN LIEU OF LENSES AND FRAMES)	
Selection Contact Lenses	$25 copayment
Selection Contact Lenses, Disposable	$25 copayment (for up to 6 boxes per year)
Non-Selection Contact Lenses OR ***Special Contact Lenses (Gas Permeable, Bifocal, Astigmatism Lenses, Etc.).***	$150 allowance toward the evaluation, fitting fees, and contact lenses
PATIENT OPTIONS	
Progressive Lenses and Tints, Etc.	No additional charge (is included in the $25 copayment for lenses)

Covered Services	You Pay…
Scratch-Coating Protection for Lenses	No additional charge (is included in the $25 copayment for lenses

Out-of-Network Provider Benefits

Service	Reimbursement Schedule
Exam	Up to $40
Single Vision Lenses	Up to $40
Bifocal Lenses	Up to $60
Trifocal Lenses	Up to $80
Lenticular Lenses	Up to $80
Frame	Up to $45
Elective Contact Lenses	Up to $150
Medically Necessary Contact Lenses	Up to $210

Reimbursement for the above services are limited to once every calendar year.

Life Insurance Benefits

The Company offers eligible employees the opportunity to participate in Employee Term Life Insurance as well as Spouse and Child Term Life Insurance. Employee Term Life Insurance is for you only and pays a benefit to your designated beneficiary in the event of your death. Spouse and Child Term Life Insurance cover your eligible spouse and children only and pay you a benefit if your covered spouse or child dies. Optional levels of Voluntary Term Life Insurance coverage are available (see "Voluntary Term Life Insurance Benefits" under "Employee Term Life Insurance.")

All life insurance benefits are paid solely by and through the insurance policies by the insurer. No life benefits are available outside of the insurance policy.

If you plan to cover a Company-recognized Domestic Partner under this life insurance, you must submit the Hartford Affidavit of Company-recognized Domestic Partnership.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

"Term Life Insurance" is coverage that pays a death benefit, but has no cash value and remains in effect only during the time premiums are being paid. These coverages are insured by The Hartford and you pay your share of the cost of Voluntary coverage, if any, through payroll deduction.

Employee Term Life Insurance

Basic Life Insurance Benefits

As an eligible employee, the Company provides you Basic Term Life Insurance coverage of one times your base annual salary when you enroll in a medical benefit option.

You may not waive your Basic Term Life Insurance Benefits.

Voluntary Term Life Insurance Benefits

The Company provides you Basic Term Life coverage equal to one times your base annual salary when you are enrolled in a company-sponsored medical option. When you are first eligible for benefits, you may elect the first level (equal to one times your annual salary) of Voluntary Term Life Insurance without providing proof of good health. You must complete a Personal Health Application from the Hartford if you wish to elect amounts greater than this (e.g., levels equal one to seven times your annual salary). Coverage that requires proof of good health becomes effective only after the Hartford approves your application and only after you (the employee) pay the first contribution, either directly or through payroll deduction. Rates for voluntary term life insurance are based on your age and the amount of coverage.

After you enroll, you may only increase your coverage by one level per year with proof of good health. The maximum Voluntary Term Life Insurance value allowed is seven (7) times your annual salary up to a maximum of $2,000,000.

Below are the options/levels of Voluntary Term Life Insurance available to employees:

- One (1) times your base annual salary
- Two (2) times your base annual salary
- Three (3) times your base annual salary
- Four (4) times your base annual salary
- Five (5) times your base annual salary
- Six (6) times your base annual salary
- Seven (7) times your base annual salary

Coverage After Age 65

Basic Life Insurance coverage for active employees age 65 and over decreases annually as shown below. If you elect Voluntary Term Life Insurance, it will not decrease at age 65 or over.

Age	Percentage of Total Benefit Elected	Age	Percentage of Total Benefit Elected
65	92%	71	56%
66	85%	72	52%
67	78%	73	48%
68	72%	74	44%
69	66%	75	41%
70	61%	76 and over	38%

Coverage If You Become Disabled

If you become permanently and totally disabled while covered, all of your Term Life Insurance coverage continues at no cost to you. To qualify for this benefit, you must become permanently and totally disabled before age 60 and up to age 65 be absent from work at least nine consecutive months because of your disability.

Permanent and total disability exists if all of the following requirements are met:

- You are not engaged in any gainful occupation
- Because of illness, injury, or both, you are completely unable to engage in any occupation for which you are reasonably fit
- Your disability is such that your inability to work will probably continue for the rest of your life.

To apply for a waiver of Basic and Voluntary Term Life Insurance contributions, you must file your claim with the Hartford between the 9th and 12th month after the date your disability began. Claims filed after the 12th month will not be considered. Contact the Benefits Service Center or the Hartford to request a claim form.

If you became disabled before January 1, 1995, and are approved for this waiver, your Basic and Voluntary Term Life Insurance coverage continues at no cost to you as long as you remain permanently and totally disabled.

The Hartford will require you to submit proof of your continuing disability at least once a year. Proof may include examination by doctors designated by the insurance company. If this proof is not submitted, coverage will terminate.

Additional Services

If you enroll for Voluntary Term Life Insurance you will be eligible to receive online:

Will Preparation and Estate Resolution Services

Travel Assistance Related Services

Identity Theft Related Services

Funeral Planning Services

Employee Assistance Programs

Beneficiary Support Services, at no cost. -.(at time of claim)

Accelerated Benefit Option

The Accelerated Benefit Option (ABO) allows terminally ill people the opportunity to receive a portion of their life insurance during their lifetime. This money can be used to defray medical expenses or replace lost income during the last months of an illness and is not subject to income tax. The remaining portion of the life insurance benefit is payable to the named beneficiary when the covered person dies.

The ABO benefit is available to employees who have Company-provided Basic and/or Voluntary Term Life Insurance (active or on sick leave) and their spouses covered under Spouse Term Life Insurance. Employees who are approved as permanently and totally disabled (as defined in Permanent and Total Disability and who continue the active amount of life insurance) are also eligible for an ABO.

To qualify for an ABO payout, the covered person must have an injury or illness that is expected to result in death within 24 months or less, with no reasonable prospect for recovery. A physician's certification is required, and all applications are subject to review and approval by the Hartford's medical department. Based on this review, the claim is either paid or denied. If it is paid, you may not later change the amount of your life insurance coverage.

ABO payout for approved claims is 80% of your total Employee Term Life Insurance (Basic and Voluntary) or Spouse Term Life coverage, up to a maximum of $500,000. Therefore, any life insurance coverage in excess of $500,000 is not eligible for the ABO. In addition, a minimum of $3,000 in life insurance coverage is required to be eligible.

Your life insurance premiums must be current at the time of the ABO application. If you are on sick leave and have allowed your coverage to default to the Company-provided amount, you are only eligible to receive ABO benefits on that coverage amount. After an ABO payout, you are no longer permitted to change life insurance coverage levels. Employees who have irrevocably assigned their life insurance benefits (as explained below) are not eligible for ABO benefits. Contact the Benefit Service Center for information and assistance in filing an application for an ABO.

Requesting the Accelerated Benefit Option

Contact the Benefits Service Center for information on filing a request for an Accelerated Benefits Option (ABO).

Filing a Claim

The Hartford insures all life insurance benefits under a group insurance policy. They also process all claims. The following is a short summary of the procedures for filing a claim for Term Life Insurance benefits:

- Upon receiving notice of an active employee's death, the supervisor should contact the Benefits Service Center to provide notification of the death. Please also refer to the Death of an Employee Forms.
- The Benefits Service Center notifies other applicable areas of the Company of your death and begins to process insurance claims or other survivor benefits and privileges.
- The Benefits Service Center determines your most recently named beneficiary and confirms the amount of life insurance.
- The Benefits Service Center sends a letter to the designated beneficiary contact verifying the amount of life insurance payable. They will enclose a Beneficiary Life Insurance Claim Statement and any other forms that each beneficiary must complete.
- When the Benefits Service Center receives the completed Beneficiary Life Insurance Claim Statement and a certified copy of the death certificate, they will ensure a claim is filed with the Hartford on behalf of your beneficiary.

The life insurance claim will be paid approximately four to six weeks after the Hartford receives all necessary documentation. For the complete claims procedures that apply, see the Claims section.

Spouse and Child Term Life Insurance Benefits

You may cover either your spouse (under Spouse Term Life Insurance) or your children (under Child Term Life Insurance), or you may cover both your spouse and your children.

Spouse and Child Term Life Insurance options are as follows:

Option	Amount of Benefit
SPOUSE TERM LIFE INSURANCE	
Level One	1 times your annual base salary
Level Two	2 times your annual base salary
Level Three	3 times your annual base salary, up to $350,000 maximum
Waive	No coverage
CHILD TERM LIFE INSURANCE	
Basic Child Life	$15,000 for each covered child
Waive	No coverage

Benefit amounts for Employee and Spouse coverage are rounded to the next nearest $100 (if not already an even multiple). Benefit amounts and contributions may increase (or decrease) during the year if you experience a pay increase (or decrease).

You may elect Child Term Life Insurance for your eligible dependent child when first eligible or at a later date, and no proof of good health is required. You may also elect Spouse Term Life Insurance for your spouse when first eligible at any level with proof of good health. Coverage becomes effective only after you (the employee) pay the first contribution, either directly or through payroll deduction.

Your spouse must complete a Personal Health Application form. You must then forward the completed form to the Hartford for review. Upon approval from the Hartford, Spouse Term Life Insurance will be added or increased for your spouse. Coverage that requires proof of good health becomes effective only after the Hartford's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction.

The following table defines pay for Employee Term Life Insurance:

Employee Status	Definition of Pay
Regular Full-time Employee	Base annual salary or annualized hourly pay plus market rate differentials, but excluding bonus and overtime
Converted Part-time Employees	Annualized hourly pay
Regular Part-time Employees	Average base salary
Employees on Temporary Assignment	Pay for the last permanent position held

You pay the entire cost for any Spouse and Child Term Life coverage you select. You elect coverage at the rate shown on your Enrollment Worksheet (or the online enrollment tool) and pay for this coverage with after-tax contributions. Your spouse's rate is based on your spouse's age, but coverage for your child(ren) is based on a flat rate, regardless of the number of children covered.

The cost of coverage for both the employee and spouse term life insurance will increase or decrease during the year if the amount of your coverage fluctuates due to changes in your pay.

Filing a Claim

All life insurance benefits are provided under a group insurance policy issued by the Hartford. The Hartford also processes and pays all claims.

The following is a short summary of the procedures for filing a claim for Spouse or Child Term Life Insurance benefits:

- Upon the death of your covered spouse or child, you or your supervisor should inform the Benefits Service Center of the death. You are the sole beneficiary for your spouse or child's term life insurance.
- After the Benefits Service Center is notified of the death, it sends you a letter verifying the amount of life insurance payable. The letter will include a *Beneficiary Life Insurance Claim Statement*.

- Complete the *Beneficiary Life Insurance Claim Statement* and return it, along with a certified copy of the death certificate, to the Benefits Service Center. Upon receipt of both items, the Benefits Service Center will submit the claim to the Hartford on your behalf.
- The life insurance claim will be paid in approximately four to six weeks after the Hartford receives all necessary documentation. You may assign part of the benefits to pay funeral expenses, (see "Assignment of Benefits" in the *Additional Life and Accident Insurance Rules* section.)
- When a spouse or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact the Benefits Service Center. For a list of allowable changes that may be appropriate at this time, see *Life Events*. For your convenience, the letter you receive from the Benefits Service Center includes a Beneficiary Designation Form. You can also make any necessary changes to the beneficiary designations you have on file online in the Benefits Service Center.

Total Control Account

When a claim is processed, the Hartford establishes a Total Control Account for you if your share is $5,000 or more (smaller amounts are paid in a lump sum). The Hartford then deposits all insurance proceeds into the account, which is an interest-bearing checking account that earns interest at competitive money market rates and is guaranteed by the Hartford. The Hartford sends you a personalized checkbook, and you may withdraw some or all of the proceeds and interest whenever necessary. In addition, the Hartford sends you a description of alternative investment options. The Total Control Account gives you complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump-sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you consult a tax advisor.

The Hartford will only pay interest on life insurance claims (to cover the time between death and date of payment) if you live in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.

Accident Insurance Benefit

The Company offers eligible employees two accidental insurance benefits:

- Accidental Death & Dismemberment Insurance (AD&D)
- Voluntary Personal Accident Insurance (VPAI)

Accidental Death & Dismemberment Insurance

As an eligible employee, you automatically receive AD&D benefits equal to 1× your annual salary from the Company, at no cost to you if you are enrolled in a company-sponsored medical option. In the event of an accidental injury, AD&D insurance pays benefits to:

- You in the case of certain accidental injuries to you; and
- Your named beneficiaries in the event of your death.

Coverage is available without regard to previous health history.

- The plan provides broad 24-hour protection, year round, including coverage during travel
- Benefits are payable in addition to any other insurance you may have.

AD&D benefits are paid solely by and through the insurance policies by the insurer. No accident benefits are available outside of the insurance policy.

Voluntary Personal Accident Insurance

As an eligible employee, you may elect to purchase VPAI for yourself and your family. In the event of an accidental injury, VPAI pays benefits to:

- You in the case of certain accidental injuries to you;
- You in the event of your covered dependent's death; and
- Your named beneficiary in the event of your death.

VPAI coverage also includes the following features:

- You pay premiums through convenient before-tax payroll deduction
- Coverage is available for you, your spouse and dependent children (if any). The amount of VPAI coverage for your covered spouse is $10,000 up to $350,000. Child AD&D provides $10,000 coverage for each dependent child, regardless of the number of children covered.

- You may select coverage in $10,000 increments up to $500,000. If you elect family coverage, the amount of insurance for your family members is a percentage of the amount elected, and is based on the composition of your family at the time of loss, as shown in the table below:

Family Covered	Amount of Benefit
Spouse Only	70% of the employee's elected benefit amount
Spouse and Children	Spouse: 60% of the employee's elected benefit amount Each child: 15% of the employee's elected benefit amount not to exceed $75,000
Children Only	Each child: 25% of the employee's elected benefit amount not to exceed $125,000

Coverage is available without regard to previous health history

- The plan provides broad 24-hour protection, year round, including coverage during travel
- Benefits are payable in addition to any other insurance you may have
- With VPAI coverage, you are also eligible for Travel Assistance Services

VPAI benefits are paid solely by and through the insurance policies by the insurer. No accident benefits are available outside of the insurance policy.

Covered Losses and Accident Benefits

A covered loss includes death, paralysis, or loss of limb, sight, speech, or hearing. AD&D and VPAI coverages pay a benefit if you (or a covered dependent for VPAI) have a loss within one year of an accidental injury. If you experience more than one loss from the same accident, the coverages pay the largest amount applicable to one loss.

The following table explains when an injury is covered as a loss:

If Injury Is To:	It Must Be:
Hand or Foot	Severed through or above the wrist or ankle joint
Arm or Leg	Severed through or above the elbow or knee joint
Eye	The entire, irrecoverable loss of sight
Thumb and Index Finger	Severed through or above the metacarpophalangeal joint (the point where the finger is connected to the hand)
Speech	An irrecoverable loss of speech that does not allow audible communication in any degree
Hearing	An irrecoverable loss of hearing in both ears, that cannot be corrected with any hearing aid or device

The following table shows the portion of benefits that the AD&D and VPAI coverages pay if you (or your covered dependent for VPAI) have an accidental injury that results in a loss:

If Injury Results In:	Benefit Is:
Death	Full benefit amount
Loss of Two or More Members (Hand, foot, eye, leg, or arm)	Full benefit amount
Loss of Speech and Hearing in Both Ears	Full benefit amount
Quadriplegia (Total paralysis of both upper and both lower limbs)	Full benefit amount
Paraplegia (Total paralysis of both legs)	Full benefit amount
Hemiplegia (Total paralysis of the arm and leg on one side of the body)	Full benefit amount
Loss of One Arm	3/4 benefit amount
Loss of One Leg	3/4 benefit amount
Loss of One Hand, Foot, or Eye	1/2 benefit amount
Loss of Speech	1/2 benefit amount
Loss of Hearing in Both Ears	1/2 benefit amount
Loss of Thumb and Index Finger on the Same Hand	1/4 benefit amount

If your accidental injury results in the loss of use of a limb (arm or leg) within one year from the date of an accident, the AD&D and VPAI Insurance Benefits pay the following benefits:

Injury	Benefit
Loss of Use of Two Limbs	2/3 benefit amount
Loss of Use of One Limb	1/2 benefit amount

Loss of use must be complete and irreversible in the opinion of a competent medical authority.

Special VPAI Benefit Features

VPAI offers several special features. These features do not apply to AD&D.

Airbag benefit: If a participant dies as the result of a motor vehicle accident and his/her safety airbag deployed during the accident, the participant will receive an additional 10 percent of the AD&D principal sum benefit, up to a maximum of $10,000. A Seat Belt benefit must be payable in order for the Airbag benefit to be payable.

Child care benefit: If you or your spouse dies as the result of an accident and your child is covered under the family VPAI, the coverage pays the surviving spouse an annual benefit of 5% of the total coverage amount (up to $7,500 per year) for the cost of surviving children's care in a licensed child care facility. This benefit is payable up to five years or until the child enters first grade, whichever occurs first.

COBRA reimbursement: If you die as a result of an accident and your spouse and child are covered under the family VPAI, the coverage pays your dependents an additional annual benefit of 3% of your VPAI coverage amount to assist them in paying for continuation of group medical coverage, up to $6,000 per year. This COBRA reimbursement benefit may be paid for up to three years or for the duration of your dependents' COBRA eligibility. To be eligible for this benefit, your spouse and dependent children must be covered under the family VPAI as well as your company-sponsored Medical Benefits Option.

Coma benefit: If you or a covered dependent becomes comatose as the result of an accident within 31 days of the accident, you receive 1% per month of the VPAI death benefit amount each month for up to 11 months. This benefit ends the earliest of:

- The month the covered person dies
- The end of the 11th month for which the benefit is payable
- The end of the month in which the covered person recovers.

This benefit is payable after a 31-day waiting period which begins on the day the covered person becomes comatose.

If the covered person remains comatose after 11 months, the coverage pays the amount of coverage for accidental death reduced by benefits already paid for injury or paralysis. If the covered person dies as the result of the accident while the coma benefit is payable, the coverage pays benefits for accidental death.

In addition to other VPAI exclusions, the coma benefit has one other exclusion. Benefits are not payable for a loss resulting from illness, disease, bodily infirmity, medical or surgical treatment, or

bacterial or viral infection, regardless of how it was contracted. However, a bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning is covered.

Coma benefits are paid to the legal guardian or person responsible for the care of the comatose patient. The claims processor determines who is most responsible if a legal guardian is not named.

Payment of the coma benefit to the legal guardian or person responsible for care does not change the designated beneficiary in the event of death.

Common disaster benefit: If you elect family VPAI coverage and, as the result of a common accident, you or your spouse dies within one year of the covered accident, the spouse's loss of life benefits will be increased to 100% of your amount of coverage. However, the combined benefits of you and your spouse will not be more than $1 million.

Counseling and bereavement benefits: VPAI pays an additional benefit if you or an insured family member dies, becomes comatose, or is paralyzed or suffers accidental dismemberment as a result of a covered accident. VPAI will pay for up to five sessions of medically necessary bereavement and trauma counseling, at a maximum of $100 per session, for expenses incurred within one year of the date of the covered accident. Benefits are payable for the insured and any of the insured's immediate family members, including mothers/fathers-in-law, and brothers/sisters-in-law.

Double benefit for dismemberment of children: If a covered child experiences a loss as the result of an accident, the benefit amount is double (to a maximum benefit of $60,000). This provision does not apply if death occurs within 90 days of the accident.

Home/vehicle modification benefit: If, as the result of an accident, the participant's covered injury(ies) require use of or accommodations to his/her home or motor vehicle, the participant will receive a benefit equivalent to 10% of his/her principal sum benefit, up to a maximum benefit of $10,000.

Escalator benefit: Your VPAI benefits will automatically increase by 3% of your elected benefit amount each year up to a maximum of 15% after five continuous years. This increased coverage is provided at no additional cost. If coverage ends for any reason, such as layoff, unpaid sick leave of absence, or termination of contributions, any previous escalator benefit is lost. A new five-year escalator benefit period starts if you decrease your coverage or re-enroll. If you increase your level of coverage, you will retain the escalator benefit that has accrued on the previous amount and will begin a new five-year escalator period for the additional amount of coverage.

This coverage applies only to accidents that occur on or after the January 1, 2001. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this coverage.

Rehabilitation benefit: If a covered person suffers an accidental loss for which benefits are payable under the policy, we will reimburse the covered person for covered rehabilitative expenses that are due to the injury causing the loss. The covered rehabilitative expenses must be incurred within two years after the date of the accident causing the loss and will be payable up to a maximum of $2,500 for all injuries caused by the same accident.

Hospital means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N).; and (4) is supervised by one or more physicians. A hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Medically necessary rehabilitative training service – As used in this coverage, means any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that: (1) is essential for physical rehabilitative training due to the injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a doctor.

Covered rehabilitative expense(s) means an expense that: (1) is charged for a medically necessary rehabilitative training service of the covered person performed under the care, supervision or order of a physician (2) does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a hospital room and board charge, does not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred); and (3) does not include charges that would not have been made if no insurance existed.

Exclusions: In addition to the exclusions in the general exclusion section of the policy, covered rehabilitative expenses do not include any expenses for or resulting from any condition for which the covered person is entitled to benefits under (1) any Workers' Compensation Act or similar law; or (2) the accident medical expense Benefit coverage.

Seat belt benefit: If you or your covered dependent dies in an accident as the driver or passenger of any land vehicle (including Company-owned cars, pickups, and commercial vehicles) and the covered person was properly wearing a seat belt at the time of the accident, the coverage pays an additional 20% of the benefit applicable to you or your dependent, to a maximum of $25,000. If the vehicle was not equipped with seat belts or the accident report shows seat belts were not in proper use, no seat belt benefit is payable.

Special education benefit: If either parent dies as the result of an accident and you, your spouse, and your children are all covered by the family VPAI, the coverage pays 5% of that parent's total coverage amount (up to $10,000 per year) to each dependent child for higher education. This benefit is payable for up to four consecutive years, as long as the child is enrolled in school beyond 12th grade. If coverage is in force but there are no children who qualify at the time of the accident, the coverage pays an additional $1,000 to the designated beneficiary.

Spouse critical period: If you or your covered spouse dies as a result of an accident, VPAI pays the surviving spouse an additional monthly benefit of 0.5% of the deceased person's coverage amount. This benefit, provided to help the surviving spouse cope with the difficult period immediately following a death, is paid monthly for 12 months.

Spouse retraining benefit: If you die accidentally and your spouse is also covered by the family VPAI, the coverage pays up to a maximum of $10,000 for your spouse to enroll as a student in an accredited school within 365 days of your death. This benefit is in addition to all other benefits.

Uniplegia benefit: If a participant is involved in an accident resulting in the loss of use of only one arm or one leg, the participant will receive a benefit equivalent to 50% of his/her principal sum benefit.

Waiver of premium: If you elect VPAI coverage for you and your dependents and you die as the result of an accident, any VPAI coverage you have elected for your spouse and children continues without charge for 24 months.

Travel Assistance Services:

If you elect VPAI coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. This package of valuable services and benefits is called CIGNA Secure Travel and is provided by Worldwide Assistance Services, Inc.

Through CIGNA Secure Travel, you have access to more than 250,000 service professionals in over 200 countries. These agents are available 24 hours a day, seven days a week to provide you with the highest level of service whenever you need it.

CIGNA Secure Travel offers the following services for international travel:

- Services before your departure, including:
  - Immunization requirements
  - Visa and passport requirements
  - Foreign exchange rates
  - Embassy/consular referral
  - Travel/tourist advisories
  - Temperature and weather conditions
  - Cultural information
- Prescription assistance to refill a prescription that has been lost, stolen, or depleted
- Assistance in replacing lost luggage, documents, and personal items
- Legal referrals to local attorneys, embassies, and consulates
- Medical referrals to local physicians, dentists, and medical treatment centers in the event of an accident or illness (The legal referral services listed in the preceding bullet are a benefit of VPAI coverage; however, you will need to pay for any professional services rendered. You must also follow your Medical Benefit Option rules in order to receive reimbursement for any eligible expenses.)

- Emergency message relay to notify friends, relatives, or business associates if you have a serious accident or illness while traveling
- Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility if medically necessary
- Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains
- Return of dependent children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized (Worldwide Assistance Services will arrange and pay for their transportation home. If someone is needed to accompany the children, a qualified escort will be arranged and expenses paid. Children do not have to be covered under VPAI for this benefit.)

If a covered member is traveling alone and must be hospitalized for 10 or more consecutive days, arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his/her home to the place where the covered member is hospitalized. (Worldwide Assistance Services will also arrange and pay for a maximum of $100 per day for up to seven days for meals and accommodations for the family member or friend while they are visiting the hospitalized covered member.)

Take care of all your beneficiary designations in one efficient online process. Visit *My Beneficiaries* in the online Benefits Service Center on my.envoyair.com. Please keep in mind that wording is important when designating a beneficiary, and you can designate an unlimited number of beneficiaries. Once the online form is completed and submitted, it supersedes all previous designations. See "Beneficiaries" in the *Additional Life and Accident Insurance Rules* section for more information on designating beneficiaries.

Terrorism and Hostile Act AD&D Insurance for Pilots and Flight Attendants

The Terrorism and Hostile Act AD&D Insurance coverage covers both the Company and its Affiliates' pilots and flight attendants while on duty, and covers accidental death, dismemberment, and permanent total disability resulting from terrorism, sabotage, or other hostile actions anywhere in the world.

The maximum benefit of this insurance is $200,000 per covered individual, and loss must occur within 365 days after the date of the covered accident.

If Injury Results In:	T&HAAI Benefit Is:
Loss of Life	Full benefit amount

If Injury Results In:	T&HAAI Benefit Is:
Loss of Two or More Hands and/or Feet	Full benefit amount
Loss of Sight of Both Eyes	Full benefit amount
Loss of Sight of One Eye	Full benefit amount
Loss of One Hand or Foot	1/2 benefit amount
Loss of Speech	1/2 benefit amount
Loss of Hearing in Both Ears	1/2 benefit amount

The aggregate maximum of all benefits paid under this insurance, per accident, is $10,000,000.

In addition, this insurance provides a permanent and total disability (PTD) benefit of $200,000 per covered individual effective January 1, 2009. If the covered individual becomes permanently and totally disabled from a covered accident; remains permanently and totally disabled for the duration of the waiting period (12 months after the date of the covered accident); and at the end of the waiting period, is certified by a physician to be disabled for the remainder of his/her life; the insurance will pay a lump sum benefit of $200,000, less any other AD&D benefit paid under the Plan for the covered loss causing the disability.

Exclusions

The AD&D and VPAI Insurance policies do not cover loss caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, suicide, or attempted suicide
- Declared or undeclared act of war within the U.S. or any nation of which you are a citizen
- An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:
    - The vehicle is being used for experimental purposes
    - You are operating, learning to operate, or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company
- Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, over-the-counter drugs)
- Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping, or burglary.

Filing a Claim

VPAI and AD&D are provided under group insurance policies issued by the Life Insurance Company of North America (LINA). CIGNA processes all claims for LINA. The following is a short summary of the procedure for filing a claim for VPAI and AD&D benefits:

- Contact the Benefits Service Center to request a CIGNA Claim Form within 30 days of the death or injury. (In the event of your death, your supervisor will notify Survivor Support Services, who will coordinate filing for VPAI and AD&D benefits, similar to the procedures outlined for life insurance claims in Term Life Insurance). Complete the form according to accompanying directions. All claims must be submitted on CIGNA forms.
- Send the completed claim form to the Benefits Service Center along with documentation of the claim (such as a police report of an accident and a certified copy of the death certificate). The Benefits Service Center sends the claim to CIGNA for processing.
- CIGNA processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this is the case with your claim, CIGNA notifies you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA’s expense.
- If your claim is approved the insurance proceeds will be deposited into a CIGNA Resource Manager Account (similar to a money market checking account) which earns interest.

- If your claim is denied, you or your beneficiary will be notified in writing. Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.
- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.
- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim. You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

For the complete claims procedures that apply, see the Claims and Appeals section.

Conversion Rights

You can convert up to $250,000 in VPAI coverage for you and your spouse and up to $10,000 in coverage for each eligible child to individual policies offered by Life Insurance Company of North America (LINA) within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends
- Your eligibility ends (However, a dependent who is no longer eligible for coverage may not convert to an individual policy while you remain eligible for coverage.)
- The coverage ends.

Contact LINA at 800-238-2125 for details on conversion.

Insurance Policy

The terms and conditions of this AD&D and VPAI coverages are set forth in the group insurance policies issued by Life Insurance Company of North America (LINA). These group policies are available for review from LINA. In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.

Other accident insurance, including Special Risk Accident Insurance and Special Purpose Accident Insurance, is provided under group insurance policies issued by LINA (see *Other Accident Insurance* below). CIGNA processes and pays all claims for LINA. To file a claim, you (or your supervisor for your beneficiary, in the event of your death) should contact the Benefits Service Center.

Other Accident Insurance

The Company and its Affiliates provide other accident insurance for certain situations described in this section. Other accident insurance programs include Management Personal Accident Insurance (MPAI), Special Risk Accident Insurance (SRAI) and Special Purpose Accident Insurance (SPAI). Benefits from these programs are payable in addition to any benefits you may receive under the AD&D and VPAI plans. These insurance coverages all have the following features:

- Premiums are paid by the Company.
- Coverage is provided without regard to your health history.

- The insurance provides 24-hour protection while you are traveling on Company business, from the time you leave until you return home or to your base, whichever occurs first.
- Benefits are payable in addition to any other insurance you may have.
- Covered losses include death or loss of limb, sight, speech, or hearing. The insurance pays a benefit if you have a loss within one year of an accidental injury. For a description of injuries and how benefits are paid, see "Accidental Death & Dismemberment Insurance
- As an eligible employee, you automatically receive AD&D benefits equal to 1× your annual salary from the Company, at no cost to you if you are enrolled in a company-sponsored medical option. In the event of an accidental injury, AD&D insurance pays benefits to:
- You in the case of certain accidental injuries to you; and
- Your named beneficiaries in the event of your death.

Coverage is available without regard to previous health history.

- The plan provides broad 24-hour protection, year round, including coverage during travel
- Benefits are payable in addition to any other insurance you may have.

AD&D benefits are paid solely by and through the insurance policies by the insurer. No accident benefits are available outside of the insurance policy.

Voluntary Personal Accident Insurance

As an eligible employee, you may elect to purchase VPAI for yourself and your family. In the event of an accidental injury, VPAI pays benefits to:

- You in the case of certain accidental injuries to you;
- You in the event of your covered dependent's death; and
- Your named beneficiary in the event of your death.

VPAI coverage also includes the following features:

- You pay premiums through convenient before-tax payroll deduction
- Coverage is available for you, your spouse and dependent children (if any). The amount of VPAI coverage for your covered spouse is $10,000 up to $350,000. Child AD&D provides $10,000 coverage for each dependent child, regardless of the number of children covered.
- You may select coverage in $10,000 increments up to $500,000. If you elect family coverage, the amount of insurance for your family members is a percentage of the amount elected, and is based on the composition of your family at the time of loss, as shown in the table below:

Family Covered	Amount of Benefit
Spouse Only	70% of the employee's elected benefit amount

Family Covered	Amount of Benefit
Spouse and Children	Spouse: 60% of the employee's elected benefit amount Each child: 15% of the employee's elected benefit amount not to exceed $75,000
Children Only	Each child: 25% of the employee's elected benefit amount not to exceed $125,000

Coverage is available without regard to previous health history

- The plan provides broad 24-hour protection, year round, including coverage during travel
- Benefits are payable in addition to any other insurance you may have
- With VPAI coverage, you are also eligible for Travel Assistance Services

VPAI benefits are paid solely by and through the insurance policies by the insurer. No accident benefits are available outside of the insurance policy.

- Covered Losses and Accident BenefitsBenefits payable under these other accident coverages do not reduce any accident benefits you may receive under the AD&D and VPAI insurance coverages.

MPAI Benefits

MPAI provides coverage for management employees while traveling on Company business and for non-occupational accident including any land or water vehicle. Coverage is three times your salary up to a maximum of $200,000.

SRAI Benefits

SRAI provides coverage for management, agent, support staff and Transportation Workers Union ("TWU") -represented employees for accidental death and dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000.

SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000. This coverage only applies to employees on active payroll. SRAI benefits are reduced by any benefits you receive under MPAI.

SPAI Benefits

This coverage applies to management, agent, support staff and TWU-represented employees. It pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

The plan also pays up to $100,000 to non-flight employees injured in an accident while riding on Company business as passengers, mechanics, observers or substitute flight attendants in any previously tried, tested and approved aircraft operated by a properly certified pilot.

Policy Aggregates

An accident may involve more than one employee. Total benefits to all covered employees involved in a single incident are limited to:

- $5,000,000 per aircraft under MPAI
- $10,000,000 per accident under SRAI
- $2,000,000 per aircraft accident under SPAI.

If benefits for one incident would exceed the limit, benefits are distributed to beneficiaries in proportion to the amounts of insurance covering all employees who suffer losses in the same incident.

Exclusions

These accident insurance policies do not cover losses caused by or resulting from any of the following:

- Suicide, attempted suicide, or intentional self-inflicted injuries
- Declared or undeclared act of war (Under SRAI, hostile acts of foreign governments are not covered within the U.S.)
- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:
  - The vehicle is used for test or experimental purposes
  - You are operating, learning to operate, or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant, or acting as a crewmember on any aircraft owned by or under contract to the Company and its Affiliates
  - Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift (MAC) of the United States of America or a similar air transport service of any other country
- Commuting to and from work (SRAI Plan)
- While a driver/occupant of any conveyance engaged in race/speed test (MPAI Plan)

Insurance Policy

The terms and conditions of the Other Accident Insurance coverages are set forth in the group insurance policies issued by the Life Insurance Company of North America (LINA). The group policies are available for review from the Plan Administrator.

In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.

Disability Benefits

The following summary helps you understand the benefits you may be eligible to receive in the event of an illness or disability. Both Optional Short Term Disability and Long Term Disability Insurance are not taxable income because you pay for this coverage with after-tax contributions.

Optional Short Term Disability Insurance

You pay the cost of your OSTD insurance on an after-tax basis. The insurance is paid by employee contributions and administered by The Hartford. No OSTD benefits are available outside of the insurance policy.

How the OSTD Insurance Works

Optional Short Term Disability Insurance (OSTD) protects you in the event you are not able to work due to a non-occupational illness or injury. If you have a qualifying disability, the OSTD benefit covers the difference between any third-party short term disability benefit and the lesser of 50% of your pre-disability earnings on your last day worked, or the weekly amount of $1,923.

For regular, full-time employees, “pre-disability earnings” is defined as your regular weekly rate of pay including market rate differentials and skill and license premiums but not counting bonuses, commissions and tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last day you were actively at work before you became disabled. For **part-time employees**, “pre-disability earnings” is defined as your regular weekly rate of pay including skill and license premiums but not counting bonuses, commissions and tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last day you were Actively at Work before you became disabled. **For pilots**, “pre-disability earnings” is defined as your regular weekly rate of pay including skill and license premiums but not counting bonuses, commissions and tips and tokens, overtime pay or any other fringe benefits or extra compensation, for the 78 hour calculation period prior to the last day you were actively at work before you became disabled.

The cost of OSTD insurance is collected through payroll deductions. If you enroll, your selection remains in effect for two (2) calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, proof of good health is required. You may add coverage if you experience a qualifying Life Event. Your OSTD insurance will not become effective until you meet the eligibility criteria described below and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD pay.

Eligibility

In order to be eligible to receive OSTD benefits, you must be “Actively at Work” on the date your insurance would become effective. “Actively at Work” or “Active Work” means that you are at work at Envoy on a day that is one of Envoy’s scheduled workdays. On that day you must be performing for wage or profit all of the regular duties of your occupation in the usual way and for your usual number of hours. The Harford will consider you actively at work on a day that is not a scheduled work day only if you were actively at work on the preceding scheduled day.

Definition of Total Disability

You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

Disabled or Disability means that **you** are prevented by:

- Injury;
- Sickness;
- Mental Illness;
- Substance Abuse; or
- Pregnancy,

from performing the Essential Duties of your Occupation, and as a result, you are earning 20% or less of your predisability earnings.

If your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute disability.

Under OSTD Insurance, you will be required to receive appropriate care and treatment (during your disability). Appropriate Care and Treatment means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating your disability
- consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research, health care coverage organizations, and governmental agencies;
- consistent with a Physician's diagnosis of your disability; and
- intended to maximize your medical and functional improvement.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefits

In some cases, OSTD benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii, and Rhode Island must apply directly to the state for benefits.
- If you have accrued a significant number of unused sick days, including long term sick days, you would not be able to collect OSTD until you have used all those days.
- If you are enrolled in Long Term Disability Insurance (LTD), you will receive the full benefit of the OSTD Insurance, plus you will receive a minimum benefit from LTD (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD are exhausted, the full LTD benefit will be payable. You must meet the definition of disabled under the LTD plan.

The OSTD benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

Filing a Claim

If your disability (as defined in this insurance benefit) continues for eight or more days, you should file your disability claim immediately. Do not wait until your sick pay is used up; *file by the eighth day of your disability*. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is 90 days after your disability began. If you are covered under a state-mandated short-term disability plan, and the state requires you to file sooner, the state's filing

deadline overrides the Company's deadline. If you file your disability claim beyond the 90 days deadline (or the state-mandated deadline, if sooner), your claim may not be accepted, and you will not be eligible for benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under OSTD Insurance, state disability plans (other than California, Rhode Island, and Hawaii, which have their own forms that must be filed directly with the respective states), and LTD Insurance. You or your supervisor should report your disability telephonically to The Hartford 1-866-216-0370 as soon as you become disabled.
- The Hartford will contact you, Envoy HR, and your attending physician for additional information.:

After The Hartford receives your claim information, your claim will be reviewed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

The Hartford is the claims administrator for Optional Short Term Disability Insurance. The OSTD and state disability coverages are insured plans (including state plans in New Jersey, New York, and Puerto Rico). The states of California, Hawaii, and Rhode Island administer their own disability plans.

Working While Disabled

You can still collect a weekly benefit if you are disabled and working. If your weekly earnings (pay you receive while you work) PLUS your weekly benefit (benefit payment you receive while you're NOT working) is more than 100% of your pre-disability earnings (as defined previously) your weekly OSTD benefit is reduced by the excess amount. In no event can the total amount you collect from all sources of income exceed 100% of your pre-disability earnings while you are disabled.

Your pre-disability earnings are determined as of your last day worked prior to you becoming disabled.

When Benefits Begin

Provided you qualify, OSTD is payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever is later. If you are collecting vacation pay when OSTD benefits become payable, OSTD will not begin until your vacation pay ends, however OSTD benefits will retro back to your 8th day of disability once benefits become payable. Benefits are payable for a maximum of 26 weeks for each period of disability.

There is no limit to the number of times you may receive these benefits for different periods of disability. A single period of disability will be considered continuous if separated by 60 days or less and is due to the same or related cause. Such disability will be considered to be a part of the original disability. The Hartford will use the same pre-disability earnings and apply the same terms, provisions, and conditions that were used for the original disability. You will be eligible to receive a maximum of 26 weeks for this single period of disability. This is a benefit to you in that if you become disabled again due to the same or related sickness or accidental injury, you will not be required to meet a new elimination period.

Recovery from a Disability

- For purposes of this subsection, the term Active Work only includes those days you actually work.

- The provisions of this subsection will not apply if your insurance has ended and you are eligible for coverage under another group short term disability plan.

If You Return to Active Work Before Satisfying Your Elimination Period

- If you return to active work before satisfying your Elimination Period and then become disabled, you will have to complete a new elimination period.

If You Return to Work After Completing Your Elimination Period

- If you return to active work full time after you begin to receive weekly benefits, we will consider you to have recovered from your disability.
- If you return to active work full time for a period of 60 days or less, and then become disabled again due to the same or related sickness or accidental injury, we will not require you to complete a new elimination period. For the purpose of determining your benefits, we will consider such disability to be part of the original disability and will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability.

Benefits from Other Sources

If you qualify for disability benefits from other sources, your OSTD benefits are reduced by the amount of the following periodic benefits. Your OSTD benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

Other Income Benefits means the amount of any benefit for loss of income, provided to you or your family, as a result of:

- governmental law or program that provides disability or unemployment benefits as a result of your job with your Employer;
- plan or arrangement of coverage, whether insured or not, which is received from your Employer as a result of
- employment by or association with your Employer or which is the result of membership in or association with any
- group, association, union or other organization;
- mandatory "no-fault" automobile insurance plan; or
- disability benefits under:
    - the United States Social Security Act or alternative plan offered by a state or municipal government;
    - the Railroad Retirement Act;
    - the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial
- pension or disability plan; or similar plan or act that you, your spouse and/or children, are eligible to receive because of your Disability.

When Benefits End

Your OSTD Insurance Benefit payments end automatically on the earliest of the following dates:

- The date no longer meet the definition disability

- The date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition
- The date you fail to furnish proof of loss
- The date your current weekly earnings are equal to or greater than 20% of your pre-disability earnings if you are receiving benefits for being disabled from your occupation
- The end of the maximum benefit period of 26 weeks
- The date you die.

If and when you return to work, you or your supervisor must notify The Hartford to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for reimbursing the OSTD Insurance for any overpayments you receive.

Exclusions and Limitations

OSTD Insurance has the following exclusions and limitations:

Exclusions: *What Disabilities are not covered?*
The Policy does not cover, and will not pay a benefit for, any Disability:

1) unless you are under the Regular Care of a Physician;

2) that is caused or contributed to by war or act of war, whether declared or not;

3) caused by your commission of or attempt to commit a felony;

4) caused or contributed to by your being engaged in an illegal occupation;

5) caused or contributed to by an intentionally self-inflicted Injury; or

6) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed.

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

1) was sponsored by your Employer; and

2) was terminated before the Effective Date of The Policy;

no benefits will be payable for the Disability under The Policy.

If you are based in California, Hawaii, New York, New Jersey, Puerto Rico, or Rhode Island, then OSTD benefits are offset. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD benefit, an OSTD benefit is payable. If the state benefit is more than the OSTD benefit, an OSTD benefit is not payable.

Preexisting conditions exclusion: You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for twelve months, this limitation on disability no longer applies, and you may receive benefits. (Also see the Glossary for the OSTD insurance benefit definition of a preexisting condition).

Long Term Disability Insurance

The LTD Insurance is fully insured by The Hartford. You pay the cost of your LTD coverage on an after-tax basis. The LTD Insurance is funded through employee contributions, insured and administered by The Hartford.

For details on the LTD Insurance, see “Long Term Disability Insurance Benefits” in the Disability Benefits section.

How the Benefit Works

The Company offers eligible employees the opportunity to participate in a Long Term Disability (LTD) Plan.

LTD benefits replace a portion of your salary when you are unable to work as a result of a disability. Most absences from work due to disability are generally of short duration and covered by paid sick time or Optional Short Term Disability (OSTD) benefits. However, some absences may continue for longer periods. LTD coverage provides you protection during these extended absences. LTD coverage also provides you the opportunity to return to work on a trial basis and to participate in a rehabilitation program. You pay the cost of LTD coverage through payroll deductions with after-tax contributions. If you choose not to enroll when you are first eligible and later decide to enroll, proof of good health is required.

The Company provides limited salary protection for non-work related disabilities through accrued sick pay and Optional Short Term Disability Insurance (OSTD) benefits. OSTD Insurance benefits end after a maximum period of 26 weeks. If you also participate in the LTD Insurance Benefit, your LTD benefits begin after the latest of:

- the date you are disabled for four consecutive months; the latest day you received salary/pay from the Company (both salary continuance [if applicable] and sick pay); or
- the last day you receive other benefits for this disability.

Definition of Total Disability

During the elimination period and the first 24 months for which LTD benefits are payable, you are considered totally disabled if you are not gainfully employed in your occupation for wage or profit, and are unable to perform major and substantial duties of your own occupation because of sickness or accidental bodily injury.

After 24 months for which benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for any employer, and are unable to perform major and substantial duties of any occupation or employment for wage or profit for which you have become reasonably qualified by training, education, or experience.

The only conditions under which you may be gainfully employed in any type of job for wage or profit and still be considered totally disabled are described under the rehabilitation program.

Should you become disabled and your occupation requires a license, a loss of that license in itself will not automatically qualify you for disability benefits.

The Company’s approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

You will be required to receive appropriate care and treatment during your disability. Appropriate Care and Treatment means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating your disability;

- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of your disability; and
- intended to maximize your medical and functional improvement.

LTD Benefits

LTD benefits are not taxable income because you pay for this coverage with after-tax contributions.

Full-time employees: Your monthly LTD benefit, together with benefits from other sources, equals 50% of your base monthly salary on your last day paid. Your maximum monthly benefit will be $8,333.

Part-time employees: Your monthly LTD benefit, together with benefits from other sources, is 50% of your base monthly salary on your last day paid.

The minimum LTD benefit for both full-time and part-time employees is the greater of 10% of your pre-disability base monthly salary on your last day worked or $100 per month.

Whether you are a full-time or part-time employee, the amount you receive from the LTD Insurance Benefit is reduced by your income from other sources..

Elimination Period

The elimination period is the waiting period before LTD benefits are payable. It extends until the latest of the following:

- The date you have been continuously totally disabled for four (4) consecutive months
- The last day of salary continuation (injury-on-duty pay or sick pay) during total disability.

Duration of Benefits

After you qualify for LTD benefits, if you remain disabled, you receive a monthly benefit for the following maximum period:

Age at Which Disability Begins	Maximum Duration of Benefits
Prior to age 63	Normal Retirement age or 48 months, if greater
63	Normal Retirements age or 42 months, if greater
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 and over	18 months

During your disability, you may be required to provide additional medical information or submit to periodic physical exams to confirm your continuing disability. LTD benefits end if you do not agree to undergo a physical exam or provide the required information.

Filing a Claim

You should file your Long Term Disability (LTD) claim as soon as you become disabled. Do not wait until your sick pay is used up or until your four-month elimination period expires — *file your*

claim immediately. The latest you can file your LTD claim is one (1) year after your disability began. If you file your disability claim beyond this one-year deadline, your claim will not be accepted and you will not be eligible for LTD Insurance Benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD, state disability plans (other than California, Rhode Island, and Hawaii which have their own forms that must be filed directly with the respective states), and LTD programs. You or your supervisor should report your disability to The Hartford telephonically at 1-866-216-0370 as soon as you become disabled.

After The Hartford receives notification of your claim and any additional information from your treating physician, your claim will be reviewed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

When Benefits Begin

Provided you qualify, LTD benefits are payable at the end of the elimination period — the latest of the following dates:

- the date you are disabled for four consecutive months;
- the latest day you received salary/pay from the Company (both salary continuance and sick pay) — sick pay must be exhausted; or
- the last day your OSTD benefits are exhausted (if applicable).

If you return to work in a capacity comparable to your pre-disability status during the elimination period, you are still considered continuously disabled if you become totally disabled again due to the same or related sickness or injury within 60 days after returning to work in your pre-disability occupation or other comparable work. However, days worked do not count toward your elimination period.

If you have received LTD benefits for an earlier disability and become totally disabled again, your most recent disability is considered part of the previous disability. However, this provision does not apply if you have returned to work in a capacity comparable to your pre-disability status for at least three months, or, if the cause of the later disability is totally unrelated to the earlier disability. If it is considered a separate period of disability, you must satisfy a new elimination period.

Benefit Termination

Benefit payments will stop on the earliest of:

1) the date you are no longer Disabled;
2) the date you fail to furnish Proof of Loss;
3) the date you are no longer under the Regular Care of a Physician;
4) the date you refuse Our request that you submit to an examination by a Physician or other qualified medical professional;
5) the date of your death;

6) the date you refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;

7) the last day benefits are payable according to the Maximum Duration of Benefits;

8) the date your Current Weekly Earnings are equal to or greater than 100% of your Pre-disability Earnings if you are receiving benefits for being Disabled from your Occupation; or

9) the date no further benefits are payable under any provision in The Policy that limits benefit duration.

If and when you return to work, you or your supervisor must contact The Hartford to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repayment of any overpayments you receive.

If your employment terminates from a sickness or injury Leave of Absence (LOA) and you are receiving LTD benefits, these LTD benefits will continue until you meet one or more of the conditions listed above. However, when you meet one or more of these conditions and your LTD benefits terminate, your LTD coverage also terminates at the same time.

Exclusions and Limitations

Long Term Disability (LTD) Insurance has the following exclusions and limitations:

- If you become disabled before the effective date, you are not covered under the LTD Insurance until you return to work and deductions are taken from your pay.
- You are not covered under the LTD Insurance for a disability if you received medical care or treatment for the disability within the three months before the effective date of coverage. However, after you have been covered for 12 months, this limitation on disability no longer applies, and you may receive benefits.
- If you are disabled due to a mental health disorder (this includes mental health disorders, emotional disease, and/or alcohol/chemical/substance abuse/dependency), disability benefits under this coverage will end when you have received a maximum of 24 months of LTD Insurance for the entire time you are covered under the LTD Insurance. This maximum benefit applies to the duration of your participation in this coverage. As part of a mental health disability, chemical abuse/dependency includes, but is not limited to, both prescription and over-the-counter medications, as well as illicit/illegal drugs; substance abuse/dependency includes, but is not limited to, any other non-drug substances such as aerosol propellants, glue, etc. However, this duration limitation will not apply to a Disability resulting from schizophrenia, dementia or organic brain disease. Should you be confined in a Hospital or Mental Health Facility at the end of this 24 month period, benefits will continue to be paid during your confinement. If you are discharged and continue to be disabled, benefits will continue up to a 90 day recovery period. If during this 90 day recovery period, you should be reconfined for at least 14 days, your benefits will continue during that confinement and one additional 90 day recovery period.

This 24-month maximum disability benefit applies whether or not you have been hospitalized, with the following exceptions:

- If you are confined in a hospital at the end of this 24-month maximum benefit period, benefits continue as long as you are confined.
- To enable a necessary recovery period, benefits also continue for up to 90 days following your release from hospital confinement, provided you were confined for at least 14 consecutive days.
- If you are reconfined during this 90-day recovery period, benefits continue during your reconfinement, together with another 90-day recovery period, provided you are reconfined for at least 14 consecutive days.
- Benefits are not payable unless you are receiving appropriate and reasonable care for your disabling conditions from a duly-qualified physician.
- Benefits are not payable if you are disabled as a direct or indirect result of committing or trying to commit a felony, assault, or other serious crime, or are engaged in an illegal occupation, regardless of whether or not you are ever charged with a crime or for engaging in an illegal occupation.
- Benefits are not payable if you are disabled as a result of intentionally self-inflicted injuries or an attempted suicide.
- Benefits are not payable if you are disabled as a result of a declared or undeclared act of war.
- Benefits are payable only to employees. Dependents are not eligible for this benefit.

Benefits from Other Sources

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

1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of your job with your Employer;
3) plan or arrangement of coverage, whether insured or not, which is received from your Employer as a result of employment by or association with your Employer or which is the result of membership in or association with any group, association, union or other organization;
4) mandatory "no-fault" automobile insurance plan; or
5) disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

that you, your spouse and/or children, are eligible to receive because of your Disability.

Other Income Benefits also means any payments that are made to you or to your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under your Employer's Retirement Plan;
2) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
3) portion of a judgment or settlement, minus associated costs, of a claim or lawsuit that represents or compensates for your loss of earnings;
4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
  a) You were receiving it prior to becoming Disabled; or
  b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;
  (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by your after-tax contributions.); or
5) retirement benefits under:
  a) the United States Social Security Act or alternative plan offered by a state or municipal government;
  b) the Railroad Retirement Act;
  c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
  d) similar plan or act;

that you, your spouse and/or children receive because of your retirement, unless you were receiving them prior to your disability.

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

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

The Hartford will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, The Hartford will assume the entire sum to be for loss of income, and the time period to be 24 months. The Hartford may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of your claim.
The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

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

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

Social Security Disability Benefits

Because the amount of LTD benefits you receive is influenced by Social Security Disability Benefits (SSDB), you must apply for SSDB as soon as possible. The Hartford will estimate the amount of your SSDB and reduce your LTD payment by that amount. If your SSDB claim is denied, provide proof of the denial to The Hartford who will adjust the claim accordingly including any offsets previously taken.

Working While Disabled

While you are disabled, you are encouraged to work if possible. Your monthly benefit will be reduced by Other Income which may reduce your disability benefit. Your monthly benefit will not be reduced by the amount you earn from working, except if this amount, your LTD monthly benefit and any income from any other source exceeds 100% of your pre-disability earnings.

After the first twenty-four months following your waiting period, The Hartford will reduce your monthly benefit by 50% of the amount you earn from working while disabled. If your attempt to return to work is unsuccessful, you may return to your former LTD status and receive your former benefit, provided you remain disabled and satisfy all other coverage provisions.

Employees who are participating in the Workers' Compensation Transitional Duty program are not eligible for this Working While Disabled program and vice versa.

Following are the steps required to participate in the working while disabled program:

- A request for consideration is initiated either by you, your supervisor, your physician, or the claims processor.
- The request is distributed to all parties above, and all must agree that you may return to work on a trial basis.
- When your return-to-work plan has been approved by all parties, The Hartford will document the plan for signature. Documentation will include the following:
  - Written agreement from your physician, supervisor, and you that you may return to work
  - Statement of approximate length of time for the trial work period
  - Statement of hours to be worked per day and rate of pay. (If hours per day vary, the claims processor will need regular bi-weekly or semi-monthly reports of earnings and hours worked.)
- The claims processor notifies you or your supervisor whether your return-to-work request has been approved.

If you are allowed to participate in the Working While Disabled Program, your supervisor must notify the claims processor of the date you return to work. In addition, if and when you can no longer work, both your supervisor and physician must send written notification to the claims processor of this change. If you return to work for the Company under this program, your supervisor should indicate "Returning to Work" on your Payroll Transaction Request (PTR).

Your LTD payroll deductions will not resume until you are actively at work under the Return-to-Work Program for one consecutive year or when you are no longer disabled.

Rehabilitation Program

If you are receiving LTD benefits, you may be eligible to receive assistance through The Hartford's Rehabilitation program.

The Rehabilitation program offers services such as:

- Return to Work on a modified basis with the goal of resuming employment for which you are qualified by training, experience and past earnings
- On-site job analysis
- Job modification/accommodation
- Vocational assessment
- Short-term skills enhancement
- Vocational training, or
- Restorative therapies to improve functional capacity to return to work.

The Case Manager handling your case will coordinate your rehabilitation program. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist or Vocational Rehabilitation Consultant who has advanced training and education to help people with disabilities return to work.

Coverage Termination:
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date The Policy no longer insures your class;
3) the date premium payment is due but not paid;
4) the last day of the period for which you make any required premium contribution;
5) the date your Employer terminates your employment; or
6) the date you cease to be a Full-time or Part-time Active Employee in an eligible class for any reason unless continued in accordance with any of the Continuation Provisions.

Health Care FSA

The Health Care Flexible Spending Account (HCFSA) allows you to set aside money on a pre-tax basis to pay for eligible health care expenses. In most cases, this money is exempt from state and local taxes as well. You benefit by being able to pay for certain expenses with tax-free money. The amount of tax savings depends on your personal situation and your effective tax percentage.

If you establish an FSA during the year, you are only eligible for reimbursement of expenses you incur after becoming an FSA participant. Additionally, you receive reimbursement from your FSAs only for eligible expenses incurred during the same calendar year in which you deposit money into your account. However, you may carry over into the next calendar year any unused funds remaining in your FSA as of December 31—and you may use these carryover funds to reimburse not only eligible expenses incurred in the same year in which the funds were deposited, but also for eligible expenses incurred from January 1 through March 15 of the following year.

Eligible expenses that can be reimbursed from your Health Care FSA (HCFSA) include medical, dental, and vision expenses, and other expenses not paid by your Medical Option, such as deductibles, copayments/coinsurance, and infertility treatment. Any amounts above the usual and prevailing fee limits (billed by out-of-network providers) may be reimbursed from your HCFSA. IRS rules specify the types of expenses eligible for reimbursement from your HCFSA.

Employees who elect participation in an HCFSA will automatically receive an FSA Debit card. If you do not activate your FSA Debit card, you will receive reimbursement automatically when eligible claims are processed. You may have to manually submit some type of expenses.

The FSA administrator is Aon Hewitt. The Aon Hewitt website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access "Frequently Asked Questions (FAQs)," and manage direct deposit and automatic rollover features. The Aon Hewitt Your Spending Account™ (YSA) website can be accessed from the online Benefits Service Center website.

Enrolling in a Flexible Spending Account

You may enroll in either a Health Care or Dependent Day Care FSA or both (if you have eligible dependents participating in day care) during the following times:

- As a new employee when first enrolling for benefits
- If you experience a qualifying Life Event such as a marriage, birth, adoption or adding an eligible dependent to your household (process your Life Event or enroll online through the Benefits Service Center on my.envoyair.com)
- During annual enrollment.

NOTE: If you elect both a Health Care and Dependent Day Care Flexible Spending Account, you should understand that the deposits and accounts are maintained separately. This means deposits to one account cannot be used to pay expenses that are eligible under the other account.

Please note that the FSA administrator cannot enroll you in an FSA. You can only enroll in an FSA through the Benefits Service Center on my.envoyair.com.

How the Health Care FSA Works

Maximum Annual Allowable Deposit

You may deposit up to $2,550 per calendar year to your HCFSA. For the year 2017, you may deposit $2,600. You have until March 15 to use your prior year's balance and until June 15 to file claims. Because of IRS rules, you lose any money in your HCFSA if you do not use it in the year in which it was deposited or by March 15th of the following year and file a claim for reimbursement by June 15th.

Changing HCFSA Options

If you stop or reduce the amount of your deposits mid-year due to a Life Event, claims from your HCFSA (for eligible health care expenses incurred before the change) are payable up to the original amount you elected to deposit. Claims for expenses incurred after the change are payable up to the amount of your newly-elected deposit amount. You forfeit part of your balance when the deposits made before your change are greater than your claims before the change.

You lose any money in your HCFSA not used during the year it was deposited or during the grace period. In addition, you can only stop or reduce your election midyear if you experience certain Life Events. (See *Life Events*). For this reason, you should give careful thought and planning to your enrollment decision and your election amount.

Who Is Covered

You may receive reimbursement of expenses for a different range of dependents, other than those covered under your selected Medical Benefit Option. Eligible dependents for the HCFSA include your spouse and your natural, step, adopted or foster children who are under age 26 (even if you don't elect coverage for them), and any individual (i) who has the same principal place of abode as you; (ii) is a member of your household, **and** (iii) for whom you provide over half of his or her support for the year.

Because of IRS rules, Company-recognized Domestic Partners are not considered eligible dependents under your HCFSA unless they are your tax-dependent.

HCFSA funds availability: Following your first deposit, the full amount of your intended deposits for the entire year is available for your use regardless of the actual balance in your account. This benefit specifies which expenses may be paid out of your HCFSA.

Eligible Expenses

If you establish a HCFSA during the year, you are only eligible for reimbursement of expenses you incur after becoming an HCFSA participant. You have until March 15 to use your prior year's balance and until June 15 to file claims.

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Expenses that can be reimbursed through a HCFSA include the following:

- Out-of-pocket expenses, deductibles, coinsurance, and copayments not paid by your Medical or Dental Benefit Options or your Vision Insurance.
- Unreimbursed out-of-pocket expenses, deductibles, coinsurance, and copayments incurred from other health, dental, or vision coverage.
- Certain types of over-the-counter items purchased without a prescription and used to alleviate or treat personal injuries or sicknesses of the employee and/or the eligible dependents may be eligible for reimbursement through your HCFSA. For instance, bandages, crutches and contact lens solution, etc. Refer to the list of eligible items by visiting the Your Savings Account™ section of the online Benefits Service Center website.

Reimbursable Expenses

Some examples of medical expenses that ***may not*** be covered under your Medical Benefits Option but ***may*** be reimbursed under your HCFSA include, but are not limited to, the following:

- Acupuncture
- Artificial insemination
- Bandages, support hose, other pressure garments (when prescribed by a physician to treat a specific ailment)
- Birth control not purchased via Express Scripts' Mail Order Pharmacy (prescription only)
- Blood, blood plasma, or blood substitutes
- Braces, appliances, or equipment, including procurement or use
- Car controls for the handicapped
- Charges in excess of usual and prevailing fee limits
- Chromosome or fertility studies
- Confinement to a facility primarily for screening tests and physical therapy
- Experimental procedures
- Foot disorders and treatments such as corns, bunions, calluses, and structural disorders
- Halfway house care
- Home health care, hospice care, nurse, or home health care aides
- Hypnosis for treatment of illness
- Immunizations
- In-vitro fertilization
- Learning disability tutoring or therapy
- Nursing home care
- Physical therapy
- Prescription drug copayments/coinsurance
- Prescription vitamins
- Psychiatric or psychological counseling

- Radial keratotomies and lasik procedures
- Sexual transformation or treatment of sexual dysfunctions or inadequacies
- Speech therapy
- Syringes, needles, injections
- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Work-related sickness or injury (not covered by Workers' Compensation).

For a full list of covered medical expenses, go to the IRS website.

Other expenses that may be reimbursed under your HCFSA include:

- Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading), and the cost of acquiring and training a dog for the deaf
- Vision expenses, including eyeglasses, contact lenses, ophthalmologist fees (not paid by the Vision Insurance Benefit), the cost of a guide dog for the blind, and special education devices for the blind (such as an interpreter).

Some examples of dental expenses that may not be covered under your Dental Option, but may be reimbursed under your HCFSA include, but are not limited to the following:

- Anesthesia
- Cleaning more than twice per year
- Charges in excess of usual and prevailing fee limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices.

The total cost of the patient's orthodontic treatment (based upon receipt of the lump sum billing from the orthodontist) will be reimbursed from your HCFSA in one lump sum, up to the amount you elected to contribute for the year. Thus, your orthodontist should bill for the total cost of orthodontia treatment in one lump sum. For additional information about coverage for orthodontia, refer to "Covered Orthodontia Expenses" under "Covered Expenses" in the *Dental Benefit* section.

Excluded Expenses

Expenses that may not be reimbursed through your HCFSA include, but are not limited to:

- Capital expenses
- Air conditioning units
- Structural additions or changes
- Swimming pools
- Whirlpool

- Wheelchair ramps
- Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis
- Health club fees and exercise classes (except in rare cases for treatment of medically — diagnosed obesity where weight loss is part of the program and other alternatives are not available)
- Marriage and family counseling
- Massage therapy without medical necessity
- Medical insurance premiums
- Personal care items including cosmetics and toiletries
- Transportation expenses for the handicapped to and from work
- Vacation travel for health purposes
- Vitamins and nutritional supplements
- Weight loss programs (unless for treatment of medically diagnosed Obesity).

For a more complete listing, visit the Aon Hewitt website.

Receiving Reimbursement

You may receive reimbursement from your HCFSA through two different methods, the Aon Hewitt Your Savings Account™ Debit card or Automatic Reimbursement.

If you select automatic reimbursement (by not activating your Debit card), you may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the Aon Hewitt website (accessible via the online Benefits Service Center).

All participants have the option to file online or paper claims with Aon Hewitt. See the Aon Hewitt website for more information.

You have until March 15 to use your prior year's balance and until June 15 to file claims.

Health care card: All FSA enrollees will receive an Aon Hewitt **Your Spending Account™ Debit** Card – this is different than your regular medical ID card. This FSA Debit Card (also referred to as the "FSA YSA Card") carries information about your FSA account(s), including your account balance(s). Your FSA YSA Card can be used at providers, pharmacies, mail order pharmacies, or other medical providers to pay for certain FSA-eligible expenses at the time and point of service. Each year that you participate in an HCFSA, your existing YSA Debit Card will be updated with your selected HCFSA amount.

When you incur an HCFSA-eligible expense (for example, when you incur an expense for a doctor's office visit), simply present your FSA YSA Debit Card to the provider. The doctor's office will bill a charge for your deductible/copayment/coinsurance, and run this charge against your FSA YSA Debit Card – the FSA Card will pay your share of the cost directly from your HCFSA to the doctor's office; thus, you don't have to pay your share from your wallet, you don't have to submit the HCFSA claim to the FSA administrator, and you don't have to wait for HCFSA reimbursement.

Any unauthorized transaction (any ineligible HCFSA expense) will be denied at the point of service, and you will be required to pay out of pocket for the portion of the expense that would have been paid by the FSA Debit Card, had the expense been HCFSA-eligible. The card will also be denied at the point of service if the charge exceeds the remaining account balance; however, your HCFSA has the full amount of your elected amount available at the first of the year, as soon as you have made the first deduction from your paycheck. See the Your Spending Account™ website for more information about using the Your Spending Account™ Debit Card.

Automatic reimbursement feature: If you prefer not to use the Aon Hewitt Y**our Spending Account™ Debit** Card and would rather have eligible expenses that are not reimbursed under your Medical Benefits Option (such as deductibles and your coinsurance amounts or copayments) automatically processed for reimbursements from your HCFSA, simply do not activate the Aon Hewitt Y**our Spending Account™ Debit** Card. Amounts not reimbursed by the Medical and/or Dental Benefit will be automatically forwarded to your HCFSA for reimbursement. Your administrator will process these claims and make reimbursement payment to you (either by mailing you a check or by making a direct deposit to your bank account, if you have elected to receive reimbursement, via direct deposit).

Filing Claims

You **must** file a claim for reimbursement from your HCFSA in the following circumstances:

- You have an expense that is eligible for reimbursement from the HCFSA and the claim is not automatically reimbursed.
- The expense is eligible for HCFSA reimbursement but is not covered by the Medical or Dental Benefit or
  Vision Insurance.
- You have an expense for certain types of over-the-counter (OTC) supplies that may be eligible for reimbursement through your HCFSA.

  Refer to the list of eligible expenses by visiting the Aon Hewitt website.
- You have stopped the account's Automatic Rollover Feature (explained above).

To file a claim you must complete a **claim form** available online through the Aon Hewitt website. Be sure to attach documentation of your expenses, i.e., a receipt from the medical service provider, to the form.

If you have other coverage, for example through your spouse's employer, you must first submit your claim to that coverage and receive the other plan's Explanation of Benefits (EOB) before filing for reimbursement from your HCFSA. You should stop the account's Automatic Reimbursement Feature by logging on to the Aon Hewitt website to access
your account.

If your claim is approved, reimbursement checks are written to you. You will also receive a statement of your account with each reimbursement check.

2-1/2 Month Carryover of Unused HCFSA Funds

You may carry over into the next calendar year any unused funds remaining in your HCFSA as of December 31-and you may use these carryover funds to reimburse eligible expenses incurred not only in the year in which the funds were deposited, but also eligible expenses incurred between January 1 and March 15, inclusive, of the following calendar year. You have until l June 15 to file claims for reimbursement. For example, if you still have $300 or unused funds in your 2015 HCFSA on December 31, 2015, that $300 can be carried over into 2016, and you have until March 15, 2016 to incur the eligible expense to be reimbursed from this carryover amount of $300. You have until June 15th to file claims for reimbursement for claims incurred in the prior year through the March 15th carryover period.

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IMPORTANT—This June 15 filing deadline applies to BOTH claims submitted for expenses incurred during the year in which you deposited the funds, AND claims incurred during the 2½ month carryover period.

Continuation of Coverage

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your FSAs are cancelled, along with your other benefits. You may elect to continue your HCFSA as part of your Continuation of Coverage options (see "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section) available through Aon Hewitt, the COBRA administrator. Aon Hewitt will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your HCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any deposits that were made and not used before your termination date.

Dependent Day Care FSA

The Dependent Day Care Flexible Spending Account (DDFSA) allows you to set aside money on a pre-tax basis to help pay for eligible day care expenses for your eligible adult and child dependents (up to age 13). In most cases, this money is exempt from state and local taxes as well. You benefit by being able to pay for certain expenses with tax-free money. The amount of tax savings depends on your personal situation and your effective
tax percentage.

If you establish an FSA during the year, you are only eligible for reimbursement of expenses you incur after becoming an FSA participant. Additionally, you receive reimbursement from your FSAs only for eligible expenses incurred during the same calendar year in which you deposit money into your account or during the carryover period. You may carry over into the next calendar year any unused funds remaining in your FSA as of December 31—and you may use these carryover funds to reimburse not only eligible expenses incurred in the same year in which the funds were deposited, but also for eligible expenses incurred from January 1 through March 15 of the following year.

The Dependent Day Care FSA (DDFSA) pays eligible day care expenses for your children and certain adult dependents while you and your spouse (if you are married) work.

The FSA administrator is Aon Hewitt for both the Health Care Flexible Spending Account and the DDFSA. The
Aon Hewitt Your Spending Account™ website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access "Frequently Asked Questions (FAQs)," and manage direct deposit and automatic reimbursement features.

Enrolling in the DDFSA

You may enroll in either a Dependent Day Care FSA during the following times:

- As a new employee when first enrolling for benefits
- If you experience a qualifying Life Event such as a marriage, birth, adoption or adding an eligible dependent to your household (process your Life Event or enroll online through the Benefits Service Center on my.envoyair.com
- During annual enrollment.

NOTE: If you elect both a Health Care and Dependent Day Care Flexible Spending Account, you should understand that the deposits and accounts are maintained separately. This means deposits to one account cannot be used to pay expenses that are eligible under the other account.

Please note that you can only enroll in a DDFSA through the Benefits Service Center on my.envoyair.com.

How the DDFSA Works

You lose any money in your DDFSA not used during the year it was deposited. In addition, you can only change your election mid-year if you experience certain Life Events (see *Life Events*). For this reason, you should give careful thought and planning to your enrollment decision and your election amount.

You may carry over into the next calendar year any unused funds remaining in your DDFSA as of December 31-and you may use these carryover funds to reimburse eligible expenses incurred not only during the same year in which you deposit money into your account, but also for eligible expenses incurred between January 1 and March 15 of the following year. For example, if you deposited money into your 2015 DDFSA to help pay for child care, you must have incurred the child care expenses during the 2015 calendar year or between January 1, 2016 and March 15, 2016, inclusive. For purposes of the DDFSA, you are deemed to have incurred expenses for a service at the time the service is provided (rendered).

Conditions for Deposit and Maximum Allowable Deposit Amounts

You and your spouse (if you are married) must be employed or actively seeking employment to be eligible to receive reimbursement from your DDFSA. This benefit limits the amount you may deposit and the type of expenses that may be paid from your DDFSA.

Your family and tax filing status determine the maximum amount you can deposit per calendar year:

- A single employee may deposit up to $5,000.
- A couple filing a joint income tax return, where both spouses participate in DDFSAs, may deposit a combined amount of up to $5,000.
- A couple filing separate income tax returns may each deposit up to $2,500.
- A couple (if both individuals are employed) may deposit up to $5,000 or the income amount of the lower-paid spouse (if it is less than $5,000).

If your spouse has no income because he or she is a full-time student, is disabled and needs day care, or is unable to take care of your dependents because of a disability, you can still make deposits to your DDFSA. These circumstances allow you to deposit up to $250 per month if you have one eligible dependent, or up to $500 per month for two or more dependents.

If you are a Highly Compensated Employee, as defined by the Internal Revenue Code, your allowable annual pre-tax contribution may be less than $5,000 per calendar year. For example, for 2016 a Highly Compensated Employee, as defined by the Internal Revenue Code is an individual who has an annual income of $120,000 or more. The DDFSA limit in 2015 for Highly Compensated Employees is $3,600. This amount may be subject to change, and you will be notified if your maximum contribution changes.

Who Is Covered

You may claim dependent day care expenses for your eligible dependents including:

- Children under age 13
- An individual who satisfies all of the requirements to be your dependent under the Internal Revenue Code (except for the requirements pertaining to the individual’s claimed dependents, marital status and gross income), if the person meets all of the following criteria:
    - Lives with you for over half of the calendar year, and
    - Is physically or mentally incapable of self-care
- Your Spouse who meets the following criteria:
    - Lives with you for over half of the calendar year, and

- Is physically or mentally incapable of self-care

Because of IRS rules, Company-recognized Domestic Partners are not considered eligible dependents under your DDFSA.

DDFSA Guidelines

Because any unused money in your DDFSA is lost at the end of the year, consider the following guidelines when enrolling in this benefit:

- Carefully determine the number of weeks of dependent care you will purchase. Estimate and deduct weeks that might include vacation, illness, school or occasions when your dependents might have free care or not require care or as many hours of care.
- Do not anticipate expenses you are not sure about, such as day care for a child not yet born. The birth of a child is considered an eligible Life Event, and you may begin participation in a DDFSA.

Eligible Expenses

Expenses paid to the following providers may be reimbursed through your DDFSA, if you can provide their Social Security or taxpayer identification number:

- A licensed child-care center or adult day care center, including church or non-profit centers
- A private kindergarten — utilized for day care of the child(ren), rather than for educational purposes. If the private kindergarten provides both day care and educational services for your dependent child(ren), only the day care portion of the kindergarten's charges are eligible for reimbursement. The private kindergarten must separate and itemize its charges on its invoices for payment, clearly separating the day care expenses from the educational expenses. If the private kindergarten cannot or will not provide a separation/itemization of charges on its invoice, no reimbursement will be made from your DDFSA
- A babysitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents)
- A housekeeper whose duties include dependent day care
- A relative who cares for your dependents but is neither your spouse nor your dependent child under age 19
- Someone who cares for an elderly or disabled dependent inside or outside your home
- Au pairs (foreign visitors to the U. S. who perform day care and domestic services in exchange for living expenses, provided the au pair agency is a non-profit organization or the au pair obtains a U. S. Social Security number for identification purposes).

Receiving Reimbursement

Participation in a DDFSA will require either online, paper or fax reimbursement. Claim forms are available online through the Benefits Service Center site.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the Benefits Service Center website.

You may file claims for eligible expenses at any time. Unlike the HCFSA, you may only be reimbursed from the DDFSA up to the amount you have actually deposited at the time you submit the claim. If your account balance is less than the amount you request, your reimbursement will only equal the amount in your account. However, unpaid amounts are automatically paid as additional deposits are made to cover them.

Because most dependent day care expenses must be paid in advance, you may receive reimbursement for these services in advance, within certain guidelines. You can request reimbursement for services pre-paid up to 30 days in advance if the care provider verifies, in writing, that advance day care payments are non-refundable.

You have until March 15 to use your prior year's balance and until June 15 to file claims.

Filing Claims

When you file a DDFSA claim, only money already deposited in your account is available to you. If your account holds less money than the amount of your claim, only the balance in your account is reimbursed to you. The remaining amount of your claim is paid to you automatically as additional deposits are made.

To file a claim, complete a Flexible Spending Account Claim Form and attach original receipts for your day care expenses. Be sure to include documentation of your expenses, including a paid receipt from your day care and the day care provider's name, address, and Social Security or taxpayer identification number. Claims not postmarked by June 15 are ineligible for reimbursement. You can also submit a claim for reimbursement on the Benefits Service Center website.

Your first claim may take up to four weeks to process. Thereafter, claims are processed weekly.

Because most employees are required to pay for dependent day care in advance, you may file a claim for prepaid expenses up to 30 days in advance, instead of waiting until services are rendered. To be reimbursed for prepaid expenses, the dependent day care provider must verify on the claim form that the advance day care payment has been received and is non-refundable. Advance payments are only reimbursable for services to be rendered within a 30-day period.

If your claim is approved, reimbursement checks are written to you. You will receive a statement of your account with each reimbursement check. You may also view your account online by visiting the claims administrator's website. Plus, if you provide your e-mail address when you visit the claims administrator's website, you will receive e-mail confirmation that your claim has been processed.

You have until June 15 of the following year to submit claims incurred during the current calendar year. Expenses incurred before you began participating in this benefit, or after you suspend/terminate this benefit are not reimbursable.

2-1/2 Month Carryover of Unused DDFSA Funds

You may carry over into the next calendar year any unused funds remaining in your DDFSA as of December 31-you may use these carryover funds to reimburse eligible expenses incurred not only in the year in which the funds were deposited, but also eligible expenses incurred between January 1 and March 15, inclusive, of the following calendar year. For example, if you still have $300 or unused funds in your 2015 DDFSA on December 31, 2015, that $300 can be carried over into 2016, and you have until March 15, 2016 to incur the eligible expense to be reimbursed from this carryover amount of $300. However, you must have incurred the eligible expense on or before March 15, 2016, and you must submit the carryover claim for reimbursement by June 15, 2016.

IMPORTANT—This June 15 filing deadline applies to BOTH claims submitted for expenses incurred during the year in which you deposited the funds, AND claims incurred during the 2½ month carryover period.

Additional Health Benefit Rules

The provisions described in this section apply to the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options, HMOs, Dental Benefit, Vision Insurance, and the HCFSA Benefit.

Qualified Medical Child Support Order

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for health and dental benefit in some situations, typically a divorce. If you are subject to a QMCSO, your choice of benefits may be affected. For example, if the child doesn't live in the same location as you, you may not be eligible for Health Maintenance Organization (HMO) coverage.

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for employees of the Company and its Affiliates. These procedures shall be effective for medical child support orders issued on or after the Omnibus Budget Reconciliation Act of 1993 (OBRA) relating to employer-provided group health plan benefits.

These Procedures are for health coverage under the Plan, consisting of the following options:

- PPO 750 Option
- PPO 1500 Option
- PPO 2500 Option
- Out of Area Option
- Health Maintenance Organization (HMO)
- Dental Benefit
- Vision Insurance

Use of Terms

The term "Plan" as used in these procedures refers to the options and benefits described above, except to the extent that a plan is separately identified.

The term "Participant," as used in these procedures, refers to a Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.

The term "Alternate Recipient" as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The term "Order," as used in these procedures, refers to a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social

Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

The term “QMCSO” or “NMSN,” as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these procedures, or a notice from a state agency ordering the coverage of an a Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSM decreed to be a QMCSO.

The term “Plan Administrator,” as used in these procedures, refers to the Company and its Affiliates acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures Upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at:

4301 Regent Blvd.
MD 240
Irving, TX 75063

In addition, QMCSOs or NMSNs should be delivered to the same address.

Upon receipt (or within 15 days of receipt) by the Plan Administrator of a request for information on health coverage or a state agency notice to enroll a child, the Plan Administrator will send out a letter notifying the requesting party that it has received the order or notice and describing the Plan’s procedures for determining whether the order is qualified or a notice is received, whether the coverage is available under the Plan to the child and the steps to be taken by the custodial parent or agency to effectuate coverage.

Upon receipt of an Order, or upon request, the Plan Administrator will advise each person or party specified in the medical child support order that, in order to be a QMCSO or NMSN, the Order must satisfy the requirements of ERISA and OBRA ‘93 before the Plan Administrator is obligated to comply with its terms. These requirements state that the Order:

- Must be a “medical child support order,” which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.
- Must relate to the provision of a medical child support and create or recognize the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.

- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or option that is not otherwise available under the Plan.

Must clearly specify:

- The name and last known mailing address of the Participant and the name and address of each alternate recipient covered by the Order
- A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined;
- The period to which the Order applies (if no date of commencement of coverage is provided, or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order).
- The name of each Plan to which the Order applies (or a description of the coverage to be provided);
- A statement that the Order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid
- The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant's pay.

The Company and its Affiliates does not provide interim coverage to any employee's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN the Company cannot be held liable if an employee's dependent is either (i) not enrolled in coverage in the Plan, or (ii) is eliminated from coverage in the Plan. In addition, neither the Company, its Affiliates, nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) an employee's dependent except upon application by the employee in accordance with the terms of the Plan, or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he or she may contact the Plan Administrator or go to the U.S. Department of Labor website for more information on QMCSOs and NMSNs and for sample NMSN Forms or obtain a sample National Medical Support Notice.

Review of a Medical Child Support Order or Notice

Not later than 20 business days after receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall review the Order to determine if it meets the criteria to make it a QMCSO or NMSN. Under OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

Procedures Upon Final Determination

The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the Participant. In addition, a copy of the appropriate health benefit guide and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant as well as the child in the coverage. Notification will occur within 40 business days of receipt of the Order or notice.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice, or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

Appeal Process

If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Company's administrator (Aon Hewitt) in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Employee Benefits Guide (the formal Plan Document and Summary Plan Description) shall be provided upon request.

Coordination of Benefits

These coordination of benefits provisions apply to health benefits described in this Guide.

This section explains how to coordinate coverage between the Company-sponsored Medical and Dental Benefit and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see "Which Plan is Primary" in this section) under any other group medical or group dental benefit/plan, your Company-sponsored Medical and Dental Benefit will coordinate to avoid duplication of payment for the same expenses. The Plan will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical and Dental Benefit were your only coverage.

If your dependent is covered by another benefit/plan and the Plan is his/her secondary coverage, the Plan pays only up to the maximum benefit amount payable under the Plan, and only after the primary benefit/plan has paid. The maximum benefit payable depends on whether the network or out-of-network providers are used.

If you or your dependent is hospitalized when coverage begins, your prior coverage is responsible for payment of medical services until you are released from the hospital. If you have no prior coverage,

the Plan will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the Plan.

If you or your dependent is hospitalized when your benefit program coverage changes from one Medical Benefits Option to another, your prior coverage is responsible for payment of eligible expenses until you or your dependent is released from the hospital.

Other Plans

The term “other group medical benefit/plan” or “other group dental benefit/plan” in this section includes any of the following:

- Employer-sponsored benefits/plans under which the employer pays all or part of the cost or takes payroll deductions, regardless of whether the plans are insured or self-funded
- Government or tax-supported programs, including Medicare or Medicaid
- Property or homeowner’s insurance or no-fault motor vehicle coverage, except if the plan participant has purchased this coverage
- Other individual insurance policies

Which Plan Is Primary

When a person is covered by more than one plan, one plan is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid. Proof of other coverage will be required from time to time.

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under any Medical Benefits Option or the Dental Plan and Medicare are paid according to federal regulations. In case of a conflict between the Medical or Dental Plan provisions and federal law, federal law prevails.
- If the coordination of benefits is on behalf of a covered child
    - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents’ ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise.

- For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. A stepchild not living in the employee's home is not an eligible dependent under the Plan, regardless of any child support order.

If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

Benefits for Individuals Who Are Eligible For Medicare

If you (or one of your dependents) are eligible for Medicare benefits, the following rules apply:

- The Plan is the primary payer — in other words, your claims go to the Plan first — if you are currently working for the Company or an Affiliate.
- If you have been receiving kidney dialysis for 12 months, you are required to enroll in Medicare after the end of this 12-month period in order to ensure full coverage under the Plan after the thirty (30) month "coordination period."
- If you become eligible for Medicare due to you (or your dependent) having end-stage renal disease, then the Plan is the primary payer for the first 30 months of Medicare entitlement (meaning that you are both eligible and enrolled in Medicare) due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer. If you and/or a dependent do not elect Medicare, but are otherwise eligible due to end stage renal disease, benefits will be paid as if Medicare has been elected and this Plan will pay secondary benefits upon completion of the thirty (30) month "coordination period."
- If you become eligible for Medicare due to becoming eligible for Social Security disability and if your coverage under the Plan is due to the current employment status of the employee, then the Plan pays primary. (For this purpose, you will only be considered to have current employment status during first six months in which you receive Company paid disability benefits that are subject to FICA tax. Generally, Medicare does not begin to pay benefits until after this period ends.)
- The Plan pays secondary and Medicare is the primary payer if you (or your dependent) are covered by Medicare, do not have end-stage renal disease and you are not currently working for the Company or an Affiliate.
- If you (or your dependent) are over age 65 and the Plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the Plan will terminate.
- The Plan pays secondary on claims to another plan that is statutorily required to pay primary to Medicare.

Benefits for Disabled Individuals

If you stop working for the Company or an Affiliate because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for Medicare

Parts A, B and D (or Parts C and D), whichever is applicable. Medicare Part A provides inpatient hospitalization benefits, Medicare Part B provides outpatient medical benefits, such as doctor's office visits, and Medicare Part D provides prescription drug benefits. Medicare is the primary plan payer for most disabled persons. If you do not elect Medicare, but are otherwise eligible due disability, benefits will be paid as if Medicare has been elected and this Plan will pay secondary benefits.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the Plan, the Plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the Plan considers eligible, the Plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any. When Medicare is the primary payer, no benefits will be payable under the Plan for eligible Medicare benefits that are not paid because you did not enroll, qualify, or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

Continuation of Coverage — COBRA Continuation

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your health benefits are cancelled, along with your other benefits. You may elect to continue your health benefits as part of your COBRA Continuation of Coverage options available through Aon Hewitt, the COBRA administrator. Aon Hewitt will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

Several of the Plan benefits, options or plans (PPO 750, PPO 1500, PPO 2500, and Out-of-Area Options Dental Benefit, HMOs, Vision Insurance and the HCFSA) provide for COBRA Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain qualifying events. If you and/or your dependents have coverage at the time of the qualifying event, you may be eligible to elect COBRA Continuation of Coverage under the following:

- Medical
- Dental
- Vision Insurance
- Health Care Flexible Spending Account for the remainder of the calendar year in which you became eligible for COBRA Continuation of Coverage. (Although you would not be able to make contributions on a before-tax basis, by electing COBRA Continuation of Coverage for this account, you would still have the opportunity to file claims for reimbursement based on the balance remaining from your Health Care Flexible Spending Account election for the year).

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents*, including future changes.

* Although a Company-recognized Domestic Partner and his/her children do not have rights to COBRA Continuation of Coverage under existing federal law, the Company and its Affiliates

currently offers them the opportunity to continue health coverage that would be lost when certain events occur, however this may change. Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children). Therefore, if you experience a COBRA-qualifying event on or after January 1, 2017, your Domestic Partners (and their children), will not be eligible for continuation coverage. However, the Company will continue to provide continuation coverage benefits for Domestic Partners that are enrolled in continuation coverage prior to January 1, 2017, meaning that they will have continuation coverage until they have exhausted their COBRA benefit.

Eligibility

Eligibility for COBRA Continuation of Coverage depends on the circumstances that result in the loss of existing coverage for you and your eligible dependents. The sections below explain who is eligible to elect COBRA Continuation of Coverage and the circumstances that result in eligibility for this coverage continuation.

COBRA Continuation of Coverage for You and Your Dependents – Qualifying Events

Change in job status (layoff or termination of employment): You may elect COBRA Continuation of Coverage for yourself and your eligible dependents, including a Company-recognized Domestic Partner and his/her children, for a maximum period of 18 months, if your coverage would otherwise end because of layoff or termination of your employment for any reason (except in the event of termination for gross misconduct). Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children). Therefore, if you experience a COBRA-qualifying event on or after January 1, 2017, your Domestic Partners (and their children), will not be eligible for continuation coverage. However, the Company will continue to provide continuation coverage benefits for Domestic Partners that are enrolled in continuation coverage prior to January 1, 2017, meaning that they will have continuation coverage until they have exhausted their COBRA benefit.

If you are disabled when you lose coverage due to change in job status: If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any eligible dependent) are disabled at any time during the first 60 days of COBRA Continuation of Coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents, including a Company-recognized Domestic Partner and his/her children. To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (Aon Hewitt) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.

COBRA Continuation of Coverage for Your Dependents Only – Qualifying Events

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of:

- Your divorce or legal separation
- Your Company-recognized Domestic Partner relationship ends (this will no longer be applicable as of January 1, 2017)
- You become entitled to (enrolled in) Medicare benefits

- Loss of eligibility because the dependent, including children of a covered Company-recognized Domestic Partner, no longer meets the Plan's definition of a dependent (for example, if a child reaches the Plan's limiting age)
- Your death
- Your Company-recognized Domestic Partner's death

If you experience more than one of these qualifying events, your maximum COBRA Continuation of Coverage is the number of months allowed by the event that provides the longest period of continuation. Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children). Therefore, if you experience a COBRA-qualifying event on or after January 1, 2017, your Domestic Partners (and their children), will not be eligible for continuation coverage. However, the Company will continue to provide continuation coverage benefits for Domestic Partners that are enrolled in continuation coverage prior to January 1, 2017, meaning that they will have continuation coverage until they have exhausted their COBRA benefit.

How to Elect COBRA Continuation of Coverage

Solicitation for COBRA Continuation of Coverage

Solicitation following layoff or termination: In the event that your employment ends through layoff or termination, you will automatically receive information from Aon Hewitt, the COBRA administrator, about electing COBRA Continuation of Coverage through COBRA.

Solicitation following a qualifying Life Event: In the event of a Qualifying Event (as shown above as for your dependents only) (divorce, legal separation, the end of a Company-recognized Domestic Partner relationship*, your entitlement to or enrollment in Medicare, a dependent reaching the limiting age for coverage, or your Company-recognized Domestic Partner's death*), you must notify the Company by processing a Life Event change *within 60 days of the event.* You can process most Qualifying Events that are also Life Events online through the Benefits Service Center on my.envoyair.com; however, in some instances, you must call **the Benefits Service Center** to process the change. For example, in the event of your death, your supervisor or a dependent must call **the Benefits Service Center** to make the appropriate notification. If the Qualifying Event is also a Life Event that involves your Company-recognized Domestic Partner, you must call **the Benefits Service Center** to process the change.

If you fail to notify the Company of a dependent's loss of eligibility *within 60 days* after the qualifying life event, the dependent will not be eligible for COBRA Continuation of Coverage, *and* you will be responsible for reimbursing the Company for any benefits paid for the ineligible person. You are also required to repay the Company for premium amounts that were overpaid for fully insured coverages.

* Your Company-recognized Domestic Partner and his/her covered dependents will be eligible to purchase COBRA Continuation of Coverage if they lose benefits as a result of the termination of your Company-recognized Domestic Partner relationship, your partner's child's loss of eligibility under the Plan, or the death of your Company-recognized Domestic Partner or yourself up to December 31, 2016. However, the Company will continue to provide continuation coverage benefits for Domestic Partners that are enrolled in continuation coverage prior to January 1, 2017,

meaning that they will have continuation coverage until they have exhausted their COBRA benefit.

Enrolling in COBRA Continuation of Coverage

Following notification of any Qualifying Event, **the Benefits Service Center** will notify you or your dependents of the right to COBRA Continuation of Coverage. When you process your Life Event, you should provide your dependent's address (if different from your own) where the Benefits Service Center can send solicitation information.

You (or your dependents) must provide written notification of your desire to elect to purchase COBRA Continuation of Coverage within 60 days of the date postmarked on the notice in order to purchase COBRA Continuation of Coverage. (See the contact list for information on **the Benefits Service Center's** address for sending the written notice).

You and your dependents may each independently elect COBRA Continuation of Coverage. Once you elect COBRA Continuation of Coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election.

Federal laws require the Company to provide a Certificate of Group Health Plan Coverage outlining your coverage under the Plan and showing the dates you were covered by this Plan. This certificate is sent to you by the Benefits Service Center (Aon Hewitt).

If you waive COBRA Continuation of Coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify the Benefits Service Center (Aon Hewitt) before your 60-day election period expires.

Refund of Premium Payments for COBRA Continuation of Coverage

If you elect COBRA Continuation of Coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you become entitled to (enrolled in) Medicare benefits, you must contact the Benefits Service Center at 1-844-843-6869 immediately, but no later than three months after you make your first premium payment in order for you to be eligible for a refund. No payments will be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month time period, the Plan will request reimbursement from you. If the amount of your premium payments for COBRA Continuation of Coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the plan receives reimbursement for your claim, the Plan will refund your premiums.

This time limit for refunds for COBRA Continuation of Coverage also applies if the Company discovers that COBRA Continuation of Coverage has been provided to you or your dependents in error.

Processing Life Events After COBRA Continuation of Coverage Is in Effect

If you elect COBRA Continuation of Coverage for yourself and later marry or *declare a Company-recognized Domestic Partner*, give birth, or adopt a child while covered by COBRA Continuation of Coverage, you may elect coverage for your newly-acquired dependents after the qualifying event.

(**Please note that effective January 1, 2017, new Domestic Partners will not be eligible for COBRA coverage**.) To add your dependents, contact **Aon Hewitt**, the COBRA administrator, at 1-844-843-6869, *within 30 days* of the marriage, Company-recognized Domestic Partner relationship, birth, or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29, or 36 months, depending on the qualifying event). This new dependent will not have the right to continue coverage on his or her own if there is a divorce, end of Company-recognized Domestic Partner relationship, or another event that causes loss of coverage**.** You may add a newborn child or a child newly placed for adoption to your COBRA Continuation of Coverage. You should notify Aon Hewitt and the Plan Administrator of the newborn or child newly placed for adoption within 60 days of the child's birth or placement for adoption. All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to COBRA Continuation of Coverage.

If you have questions regarding COBRA Continuation of Coverage, contact **the Benefits Service Center/Aon Hewitt** at 1-844-843-6869.

Paying for or Discontinuing COBRA Continuation of Coverage

To maintain COBRA Continuation of Coverage, you must pay the full cost of COBRA Continuation of Coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect COBRA Continuation of Coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month's coverage. If you elect COBRA Continuation of Coverage, you will receive a payment invoice from Aon Hewitt indicating when each payment is due. Payments are due even if you have not received your payment coupons. Failure to make the required payment on or before the due date, or by the end of the grace period will result in termination of COBRA coverage, without the possibility of reinstatement. All checks shall be made payable to the Company and sent to:

Envoy Air Inc.
P.O. Box 1352
Carol Stream, IL 60132-1352

When COBRA Continuation of Coverage Begins/Ends

When COBRA Continuation of Coverage begins: If you or your dependents elect COBRA Continuation of Coverage within 60 days of the date postmarked on your notice, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for COBRA Continuation of Coverage includes payment for this retroactive coverage period.

When COBRA Continuation of Coverage ends: COBRA Continuation of Coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29, or 36 months) expires (See "Eligibility under Continuation of Coverage – COBRA Continuation)
- Payment for COBRA Continuation of Coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment. If full payment is not received (postmarked) within the grace period

specified on the invoice, your coverage will be terminated, without the possibility of reinstatement

- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is entitled to COBRA Continuation of Coverage up to the maximum time period.
- The Plan participant continuing coverage becomes entitled to Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See also "Dependents of Deceased Employees" under "Dependent Eligibility" in the *General Eligibility* section.

Other Special Rules

Other Health Care Options

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Plan coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of your COBRA Continuation of Coverage if you get COBRA Continuation of Coverage for the maximum time available to you. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Questions

If you have any additional questions about COBRA Continuation of Coverage you should contact Aon Hewitt (see "Contact Information" in the *Reference Information* section).

Other Employees Obligations

In order to protect you and your family's rights, you should keep both **the Benefits Service Center/Aon Hewitt** and the Company informed of any changes in the addresses of your family members.

Surviving Spouses of Active Employees

If your spouse* was covered under any Company-sponsored Medical Benefits Option, he or she remains eligible for that option for 90 days after your death with no contributions. At the end of 90 days, your spouse* may elect Continuation of Coverage under COBRA for up to 36 months (including the 90 days). See "Continuation of Coverage — COBRA Continuation."

* If you die while you and your Company-recognized Domestic Partner are covered under any Company-sponsored Medical Benefit Option, your surviving Company-recognized Domestic Partner receives medical coverage for 90 days from the date of your death. At the end of the

90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of coverage are included in the 36 months.

Additional Life and Accident Insurance Rules

This section includes rules that apply to the life and accident insurance.

Beneficiaries

In the event of your death, Life Insurance coverage benefits are paid to the named beneficiaries on file with **the Benefits Service Center**.

Unless prohibited by law, your life insurance benefits are distributed as indicated on your Beneficiary Designation Form on file with **the Benefits Service Center**. For this reason, you should consider updating your beneficiary designation periodically, especially if you get married, declare a Company-recognized Domestic Partner, or you or your spouse give birth or adopt a child, or if you get divorced or cease to have a Company-recognized Domestic Partner relationship. Beneficiary Designation can be completed online in the Benefits Service Center.

The table below provides sample wording for the most common beneficiary designations:

Type of Designation	Sample Wording*
One Person, Related	Jane Doe, spouse
One Person, Not Related	Jane Doe, friend
Your Estate	Estate
Member of a Given Religious Order	Mary L. Jones, known in religious life as Sister Mary Agnes, niece
Two Beneficiaries with the Right of Survivorship	John J. Jones, father, and Mary R. Jones, mother, equally or to the survivor
Three or More Beneficiaries with the Right of Survivorship	James O. Jones, brother, Peter I. Jones, brother, Martha N. Jones, sister, equally or to the survivor(s)
Unnamed Children	My children living at my death
One Contingent Beneficiary	Lois P. Jones, wife, if living; otherwise, Herbert I. Jones, son
Unnamed Children as Contingent Beneficiaries	Lois P. Jones, wife, if living; otherwise, my children living at my death
Trustee (A trust agreement must be in existence)	ABC Trust Company of Newark, NJ, Michael W. Jones, Trustee, in one sum, under Trust Agreement dated (insert date)

* Always include your beneficiary's address

If none of the suggested designations meets your needs, contact an attorney for assistance.

When a beneficiary is a minor (under the legal age defined by the beneficiary's state of residence), a guardian must be appointed in order for the life insurance benefits to be paid. The Hartford requires a certified court document appointing the guardian of the minor's estate or property. If the beneficiary

does not have a guardian, the life insurance benefits will be retained by The Hartford and interest will be compounded daily until the minor child reaches the legal age.

To avoid complications in paying beneficiaries, an organization or endowment should not be named unless it is a legal entity (has a legal existence, such as a corporation or trust that has been legally established). If you designate a trust, The Hartford assumes that the designated trustee is acting in proper fiduciary capacity unless written notice to the contrary is received at the home office of The Hartford. The Hartford and the Company are not liable for any payment made to a trustee before receiving such written notice. If the full amount of your insurance is not payable to the trustee or if a testamentary trustee is named, write to The Harford for assistance in proper documentation.

If your beneficiary is not living at the time of your death, the benefits under your coverage are paid to the first class of surviving family members in the order outlined below:

- Spouse
- Children or stepchildren
- Parents
- Brothers and sisters
- Estate

For dependent coverage, you are the sole beneficiary. If a covered dependent dies at the same time or within 24 hours of your death, benefits are divided equally among members of the first class of beneficiaries in which there is a relative of the covered dependent. The classes of beneficiaries are listed above in the order they would be considered.

If your beneficiary does not survive you (for example, you are both killed in a common disaster) benefits are paid to your estate according to the terms of the policy.

Take care of all your beneficiary designations in one efficient process available online at **the Benefits Service Center** on my.envoyair.com. Please keep in mind that wording is important when designating your beneficiary, and you can designate an unlimited number of beneficiaries. Once the online form is completed and submitted, it supersedes all previous designations. If your marriage or Company-recognized Domestic Partner relationship ends, you should immediately complete new beneficiary designations.

Accident Insurance Beneficiaries

You are the beneficiary for all covered losses resulting from accidental injury. You should designate a beneficiary to receive benefits in the event of your accidental death. If you do not designate a beneficiary, your beneficiary is the same as your Term Life Insurance beneficiary. If your beneficiary is not living at the time of your death, benefits are paid according to the terms of the insurance policy.

Taxation of Life Insurance

If your total coverage is more than $50,000, you may owe taxes on the value of your coverage over $50,000. This value is called imputed income. IRS regulations require the Company to report employee federal wages and deduct Social Security taxes (FICA) on imputed income from your paycheck and report it on your Form W-2 each year (see example).

Under IRS regulations, imputed income is based on your age and the monthly cost per $1,000 of life insurance over $50,000. To determine your monthly amount of imputed income, multiply the rate in the following IRS table by the amount of your insurance coverage over $50,000.

Age of Employee on December 31	Monthly Cost of $1,000 of Insurance
Under 25	$.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.66
65-69	1.27
70 and over	2.06

An example of how imputed income works:

Assume a 30-year-old employee earning $3,000 per month selects three times salary of Voluntary Term Life Insurance coverage. The following calculations show the employee's taxable imputed income:

1. Figure the amount of Term Life Insurance coverage:

   $36,000 salary × 3 = **$108,000**

2. Figure the taxable amount of coverage (amount over $50,000):

   $108,000 – $50,000 = $58,000

3. Divide that amount by $1,000:

   $58,000 / $1,000 = 58

4. Multiply the result by the IRS rate from the table above for an employee who is age 30:

   58 × $0.08 = $4.64

The monthly imputed income shown on this employee's paycheck will be $4.64. This is the amount that is subject to federal income and Social Security taxes. Spouse and Child Term Life Insurance are purchased after-taxes. Therefore, it is not subject to taxation as imputed income.

Portability and Conversion

Portability

Voluntary Term Life Insurance has a portability feature which means you may continue your life insurance coverage if you leave the Company or an Affiliate or retire. The rates for this continuing coverage are not the same as those you pay as an active employee, but they are preferred group rates based on your age. The Hartford will provide the rate schedule if you apply for portability. The minimum amount of coverage you may continue is $20,000 and the maximum amount is your current voluntary amount of life insurance coverage. Spouse, Child and Basic Life Insurance may not be continued under the portability feature. (However, Spouse, Child and Basic Life Insurance may be converted to an individual policy.) To apply for this continuing coverage, you must submit an application form to The Hartford within 31 days after you leave or retire from the Company.

Contact **the Benefits Service Center** to request a portability application or call The Hartford toll free at 1-866-216-0370 to discuss provisions relating to portability plans.

Conversion

Subject to policy provisions, you can convert all or any part of your Basic and/or Voluntary Term Life Insurance coverage to a personal policy (other than term life insurance) offered by The Hartford without providing proof of good health, if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Term Life Insurance coverage
- The coverage ends, and you have been covered under this insurance for at least five years
- Coverage for your particular job classification ends, and you have been covered under this insurance for at least
five years

If you are applying for a personal policy because your employment terminated, the amount of the policy may not be more than the amount of your Term Life Insurance on the day your coverage ended.

If you are applying for a personal policy because this Plan ended or changed, and you have been covered for at least five years, the amount of your policy will not be more than the lesser of the following:

- The amount of your coverage on the day it ended, less any amount of life insurance you may be eligible for under any group policy that takes effect within 31 days of the termination of this coverage
- $10,000.

You or your spouse or child can convert all or any part of the Spouse or Child Term Life Insurance coverage to a personal policy (other than term life insurance) offered by The Hartford if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Spouse or Child Term Life Insurance coverage
- The coverage ends and your spouse or child has been covered under this insurance for at least five years
- Coverage for your particular job classification ends and your spouse or child has been covered under this insurance for at least five years

- You die
- Your spouse or child no longer qualifies as a dependent.

To convert to a personal policy, you must call The Hartford toll free at 1-866-216-0370 to begin the conversion process.

If you or your dependent should die during the 31-day period, whether or not you have applied for the conversion policy or portability, The Hartford will pay the appropriate beneficiary a death benefit equal to the amount of life insurance you had on the date coverage terminated.

Verbal Representations

Nothing you say or that you are told regarding this insurance is binding on anyone unless you or your beneficiary have something in writing from the Company and The Hartford confirming your coverage.

Assignment of Benefits

You may irrevocably assign the value of your life insurance coverage. This permanently transfers all right, title, interest, and incidents of ownership, both present and future, in the benefits under this insurance coverage. Anyone considering assignment of life insurance coverage should consult a legal or tax advisor before taking such action.

If you assign your benefits, you are obligated to fulfill any conditions you have agreed to with your assignee. The Hartford's only obligation is to pay the life insurance benefits due at your death.

Your beneficiary may assign a portion of his or her benefit directly to the funeral home to cover the cost of the funeral. To assign benefits to a funeral home, the beneficiary signs an agreement with the funeral home. The funeral home sends a copy of the signed agreement and an itemized statement of funeral expenses to Envoy Survivor Support or The Hartford. When The Hartford processes the claim, a separate check for this portion of the benefit will be paid directly to the funeral home.

Total Control Account

When a claim is processed, The Hartford establishes a Total Control Account for each beneficiary whose share is $5,000 or more. (Smaller amounts are paid in a lump sum.) All insurance proceeds are deposited into this interest-bearing checking account that pays competitive money market interest rates and is guaranteed by The Hartford.

The Hartford sends a personalized checkbook to your beneficiary, who may withdraw some or all of the proceeds and interest whenever necessary. In addition, The Hartford sends descriptions of alternative investment options to your beneficiary. The Total Control Account gives your beneficiary complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump-sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you or your beneficiary contact your tax advisor.

The Hartford will only pay interest on a life insurance claim (to cover the time between death and date of payment) if the beneficiary lives in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.

Plan Administration

This section includes administrative information about your benefits.

Plan Information

The Company is the Plan's "plan sponsor" as that term is defined under ERISA Section 3(16)(B). The Plan's plan number is 501. All the benefits that are offered under the Plan share the same plan number (501).

The Group Health and Welfare Benefits Plan for Employees of Envoy Air Inc. and Its Affiliates.

This plan includes:

- Medical
  - PPO 750 Option
  - PPO 1500 Option
  - PPO 2500 Option
  - Out-of-Area Option
  - Health Maintenance Organization
- Dental
- Vision Insurance
- Term Life Insurance
- Optional Term Life Insurance
- Spouse and/or Child Term Life Insurance
- Accidental Death & Dismemberment Insurance
- Voluntary Personal Accident Insurance
- Special Risk Accident Insurance
- Special Purpose Accident Insurance
- Management Personal Accident Insurance
- Optional Short Term Disability Insurance
- Long Term Disability Insurance
- Health Care Flexible Spending Account
- Dependent Day Care Flexible Spending Account
- Critical Illness
- Employee Assistance Program
- Legal plan

Administrative Information

Plan Sponsor and Administrator

Envoy Air, Inc.

Mailing address:

4301 Regent Blvd.
MD 240
Irving, Texas 75063

The Plan Administrator for Second Level Administrative Appeals

Envoy Benefits Administration Committee (EBAC)
Envoy Air Inc.
4301 Regent Blvd.MD 240
Irving, TX 75063

Agent for Service of the Legal Process

Vice President Human Resources
Envoy Air Inc.

Mailing address:

4301 Regent Blvd.
MD 240
Irving, Texas 75063

Claims Processor

The claims processors for each benefit or plan vary and are listed in "Contact Information" in the *Reference Information* section.

Employer ID Number

38-2036404

Plan Year

January 1 through December 31

Participating Affiliates

Envoy Air Inc.

Executive Airlines, Inc.

Eagle Aviation Services, Inc.

Plan Amendments

The EBAC, under the authority granted to it by the Board of Directors through the Chief Executive Officer of Envoy Air Inc., has the sole authority to interpret, construe, determine claims, and adopt and/or amend employee benefit plans. The EBAC, in consultation with actuaries, consultants, Employee Relations, Human Resources, and the Legal Department, has the discretion to adopt such rules, forms, procedures, and amendments it determines are necessary for the administration of the

Plan according to their terms, applicable law, regulation, collective bargaining agreements, or to further the objectives of the Plan. The EBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the EBAC.

The administration of the Plan shall be under the supervision of the Plan Administrator. The Employer hereby grants the EBAC the authority to administer and interpret the terms and conditions of the Plan and the applicable legal requirements related thereto. It shall be a principal duty of the EBAC to see that the administration of the Plan is carried out in accordance with its terms, for the exclusive purpose of providing benefits to Participants and their beneficiaries in accordance with the documents and instruments governing the Plan. The EBAC will have full power to administer the Plan in all of their details, subject to the applicable requirements of law. For this purpose, the EBAC's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by the Plan:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information
- To interpret and construe the terms of the Plan, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plan
- To decide all questions concerning the Plan, and to determine the eligibility of any person to participate in or receive benefits under the Plan and to determine if any exceptional circumstances exist to justify any extensions
- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plan and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan
- To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such action to be by written instrument and in accordance with ERISA Section 405; and
- To delegate its authority to administer Claims for benefits under the Plan by written contract with a licensed third party administrator
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the EBAC.

Plan Funding

The coverage for the following benefits is self-funded through both Company and employee contributions:

- PPO 750 Option
- PPO 1500 Option
- PPO 2500 Option

- Out of Area Option
- Dental Benefit
- Employee Assistance Program

Health Maintenance Organizations (HMOs) are fully insured and are funded through both Company and employee contributions.

Coverage for the following benefits is fully insured and premiums are paid by the Company:

- Basic Term Life Insurance
- Basic Accidental Death & Dismemberment Insurance
- Special Risk Accident Insurance
- Special Purpose Accident Insurance
- Management Personal Accident Insurance

The following benefits are fully insured and paid entirely by employee contributions:

- Optional (Voluntary) Levels of Employee Life Insurance
- Spouse and/or Child Term Life Insurance
- Optional Short Term Disability Insurance
- Vision Insurance
- Voluntary Personal Accident Insurance
- Long Term Disability Insurance
- Critical Illness
- The Legal Plan

Collective Bargaining Agreement

The types of benefits (medical and dental benefit, life insurance benefits) described in this Guide are maintained subject to a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator at no charge. This agreement is also available for review during normal business hours at the corporate offices of the Company (see "Contact Information" in the *Reference Information* section).

Claims & Appeals Procedures

Confidentiality of Claims

The Company treats your medical information as confidential and discloses it only to the extent permitted by The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). For additional information, see "Compliance with Privacy Regulations."

Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see Assignment of Benefits). Benefits are paid after the claims processor receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the claims processor may pay all or part of the benefit to:

- Your guardian.
- Your estate.
- Any institution or person (as payment for expenses in connection with the claim).
- Any one or more persons among the following relatives: your eligibility Company-recognized Domestic Partner, parents, children, brothers, or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

The right to benefits under the Plan may not be exchanged for, or substituted for, other benefits or cash compensation.

Right to Recovery

If claims payments are more than the amount payable under the Plan or for a participant who is not covered by the Plan, the claims processor may recover the overpayment. The claims processor may seek recovery from one or more of the following:

- Any plan participant to or for whom benefits were paid,
- Any other self-funded plans or insurers,
- Any institution, physician, or other service provider, or
- Any other organization.

The claims processor is entitled to deduct the amount of any overpayments from any future claims payable to you or your service providers. The Plan reserves the right to refer any outstanding request for overpayment to an outside collection agency if internal collection efforts are unsuccessful. The Plan may also bring a lawsuit to enforce its right to recover overpayments.

Subrogation

Subrogation is third party liability. Subrogation applies if the plans have paid any benefits for your injury or illness and someone else (including any insurance carrier) is, or may be, considered legally responsible.

The Plan has the right to collect payment from the third party (or its insurance carrier) for the medical treatment of your injury or illness. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion. The Plan's subrogate (substitute) their own rights for your rights and have a lien of first priority on any recovery you receive. This means the Plan must be paid first from any settlement or judgment you receive and the Plan shall have a lien of first priority over any recovery you receive that will not be reduced by any "make whole" or similar doctrine. The Plan has the right to recover interest on the amount paid by the Plan because of the injury, sickness or other condition, and that the Plan has the right to 100 percent reimbursement in a lump sum. The Plan may assert this right to pursue recovery independently of you.

As a condition for receiving benefits under the Plan, you agree to:

- Cooperate with the Plan to protect the Plan's subrogation rights
- Provide the Plan with any relevant information they request
- Obtain consent of the Plan before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plan's subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plan's subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plan.
- The Plan's claims and lien shall not be reduced by any "make whole" or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plan.

The Plan will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plan will not pay your or others' legal costs associated with subrogation. Moreover, the Plan is not subject to any state laws or equitable doctrines, including but not limited to the "common fund" doctrine, which would purport to require the Plan to reduce its recovery by any portion or your attorney's fees or costs, regardless of whether funds recovered are used to repay benefits paid by the Plan.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this section. If you fail to cooperate as provided herein, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future

benefits otherwise payable under the Plan the amount of benefits advanced under this section to the extent not recovered by the Plan.

Assignment of Benefits

Nonalienation of Benefits. No benefit, right or interest of you, a dependent or beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action, shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you, but only as a convenience to you. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you under any circumstances.

For information about assigning life insurance benefits, see "Assignment of Benefits" in the *Additional Life and Accident Insurance Rules* section.

Time Frame for Initial Claim Determination

Unless otherwise provided in the applicable insurance policy/evidence of coverage, your claim for benefits will be processed under the procedures described below.

Medical, Dental and Vision Claims

For claims for medical, dental and vision benefits, the processing rules vary by the type of claim. For **Urgent Care claims** and **pre-service claims** (claims in which the service has not yet been rendered and/or that require approval of the benefit or precertification before receiving medical care), the Network/Claim Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- As soon as possible after receipt of a claim initiated for **Urgent Care**, but no later than 72 hours after receipt of a claim initiated for Urgent Care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification); and
- Fifteen days after receipt of a **pre-service claim**.
- For **post-service claims** (claims that are submitted for payment after you receive medical care), the Network/Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim.

An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For **Urgent Care claims**, if you fail to provide the Network/Claim Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Network/Claim Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The Network/Claim Administrator’s receipt of the requested information
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the Network/Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Network/Claim Administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for **pre- and post-service claims** due to your or your authorized representative’s failure to submit necessary information, the Plan’s time frame for making a benefit determination is stopped from the date the Network/Claim Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan’s procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving **Urgent Care**) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters
- Is a communication that names you, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

Urgent Care Claims

Urgent Care claims are those that, unless the special Urgent Care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient’s life, health or ability to regain maximum function

- In the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits
- An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the Urgent Care definition has been satisfied. However, if a Physician with knowledge of the patient's medical condition determines that the claim involves Urgent Care, it must be considered an Urgent Care claim

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined earlier, your request will be decided within 24 hours after receipt of the claim by the Plan, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the Urgent Care claim time frames described earlier.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

Health Care Flexible Spending Account

For claims under the Health Care Flexible Spending Account, Aon Hewitt will notify you of an adverse benefit determination within 30 days after receipt of a claim. A 15-day extension may be allowed to make a determination, provided that Aon Hewitt determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, Aon Hewitt must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If your claim for benefits is denied, in whole or in part, Aon Hewitt shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The notice shall contain:

- Specific reasons for the denial,
- Specific references to the Plan provisions on which the denial is based,
- A description of any information or material necessary to perfect the claim,
- An explanation of why this material is necessary, and
- An explanation of the Plan's appeal and review procedure, including a statement of the participant's right to bring a civil action under section 502(a) of ERISA, as amended, following an adverse benefit determination on review.

Dependent Care Flexible Spending Account

If your Dependent Care Flexible Spending Account claim is denied in whole or in part, you will be notified in writing by Aon Hewitt within 30 days after the date Aon Hewitt received your claim. You (or your authorized representative) may request review upon written application to Aon Hewitt. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. Appeals will be reviewed and decided by Aon Hewitt in a reasonable time not later than 60 days after Aon Hewitt receives your request for review. You will receive a notice of determination from Aon Hewitt.

If You Receive an Adverse Benefit Determination on a Medical, Dental or Vision Claim

The Network/Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- Date of service, the health care Provider, the claim amount (for Medical claims)
- The specific reason(s) for the adverse benefit determination, including a description of the Plan's or Insurer's standard, if any, used in denying the claim.
- References to the specific Plan provisions on which the benefit determination is based
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for internal appeal or external review, and will not trigger the start of an internal appeal or external review) (for Medical claims)
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures, including information regarding how to initiate an appeal, and the time limits applicable to those procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after an appeal of an adverse benefit determination.

- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits
- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim
- The Network/Claim Administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale
- The availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review procedures

Disability Claims

All Disability claims must be submitted in such written, telephonic or electronic format and must contain such information as may be prescribed by The Hartford. After The Hartford has reviewed the claim for Disability benefits and obtained any other information that it deems necessary or relevant, The Hartford shall notify you within a reasonable period of time not to exceed 45 days after receipt of the acceptance or denial of the claim. The 45-day period during which a claim for Disability benefits is reviewed may be extended by The Hartford for up to 30 days, provided The Hartford both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided The Hartford notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made.

If your claim for Disability benefits is denied, in whole or in part, The Hartford shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The notice shall contain:

- Specific reason or reasons for the denial

- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of ERISA, as amended, following an adverse benefit determination on review
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided free of charge upon request.

All Other Claims

This section applies to the following benefits:

- Employee Term Life Insurance;
- Spouse Term Life Insurance;
- Child Term Life Insurance;
- Accidental Death & Dismemberment Insurance (Employee, Spouse, Child)
- Special Purpose Accident Insurance
- Special Risk and Accident Insurance
- Management Personal Accident Insurance (For Management, Specialist and Officer employees)
- Voluntary Personal Accident Insurance (for flight attendants and pilots)
- Terrorism and Hostile Act Accident Insurance

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the Claim Administrator. After the Claim Administrator has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the Claim Administrator shall notify you within a reasonable period of time not to exceed 90 days after receipt of the acceptance or denial of the claim. The 90-day period during which a claim for benefits is reviewed may be extended by the case manager or Claim Administrator for up to 90 days, provided the Claim Administrator both determine that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 90-day period provided the Claim Administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for benefits is denied, in whole or in part, the Claim Administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The notice shall contain:

- Specific reasons for the denial,

- Specific references to the Plan provisions on which the denial is based,
- A description of any information or material necessary to perfect the claim,
- An explanation of why this material is necessary, and
- An explanation of the Plan's appeal and review procedure, including a statement of the participant's right to bring a civil action under section 502(a) of ERISA, as amended, following an adverse benefit determination on review

Effect of Failure to Submit Required Claim Information

If the Network/Claim Administrator determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the Network/Claim Administrator request for information or upon a demonstration to the satisfaction of the Network/Claim Administrator that under the circumstances the Network/Claim Administrator request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the Network/Claim Administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the Network/Claim Administrator deems relevant.

Appealing a Denial

Unless otherwise provided in the applicable insurance policy/evidence of coverage, you must file your appeal within the deadlines set forth below.

This contains appeal information and requirements

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continues to provide updated regulations, clarification and guidance on these claim procedures, the Company, as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Important Information about Health Care Provider's Appeals

As a participant in the Plan, you have the right (under federal law known as ERISA) to appeal adverse benefit determinations through the Plan's two-tiered appeal processes, as described in this section of the Guide.

However, your Network health care Providers, through their Provider contracts with the Network/Claim Administrator, also have the option to appeal adverse benefit determinations — to the extent that the adverse benefit determinations affect their benefit payments from the Network/Claim Administrator. Your Network health care Providers may appeal directly to the Network/Claim Administrator — with or without your knowledge and/or consent. These “Provider appeals” are separate and distinct from your appeal rights under ERISA, *unless the Providers specify that their Provider appeals are being filed with the Network/Claim Administrator on your behalf.*

If the Provider *specifies* in its appeal that the appeal is being filed on your behalf, the appeal *will be considered* your ERISA First Level Appeal filed with the Network/Claim Administrator. If the Provider *does not specify* in its appeal that the appeal is being filed on your behalf, the Provider’s appeal *will not be considered* as your ERISA First Level Appeal. Thus, if you then decide to appeal the adverse benefit determination, you must file both the First Level and Second Level Appeals, as described in this section of the Guide (or if the appeal is an Urgent Care appeal, you must file under the “Urgent Care appeal” process, as described in this section of the Guide).

Procedures for Appealing an Adverse Benefit Determination

Appeals may be filed on adverse benefit determinations such as claim denial or reduction in benefits, eligibility/enrollment denial, partial payment or partial denial of benefits, rescission of coverage, application of a benefit penalty, or other such adverse benefit determinations. The Company, as Sponsor and Administrator of the Plan, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. For Flexible Spending Account Benefits, the First Level Appeal will be handled by the benefits administrator and the Second Level Appeal will be conducted by the EBAC.

For administrative, eligibility, and enrollment issues on any and all employee welfare benefits or plans offered, the First Level Appeal will be conducted by **the Benefits Service Center** and the Second Level Appeal will be conducted by the EBAC.

This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered process is an appeal for an Urgent Care claim – for Urgent Care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for Urgent Care claims) and must exhaust all administrative remedies to resolve any claim issues. Second Level Appeals for Urgent Care for medical treatment should be submitted to Blue Cross Blue Shield of Texas. Second Level Appeals for Urgent Care for prescription drug coverage should be submitted to Express Scripts, Inc.

With respect to adverse benefit determinations made on fully insured benefits, the appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The EBAC cannot render a decision involving fully insured benefits (except for administrative, eligibility and enrollment issues, as stated previously). The insurers and HMOs make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process, and you should contact the respective insurer or HMO for information on how to file an appeal (see "HMO Contact Information" in the *Health Maintenance Organizations (HMOs)* section.) For purposes of this paragraph, "fully-insured benefits" include the following:

- Employee Term Life Insurance (Employee, Spouse, and Child)
- Accidental Death and Dismemberment Insurance (Employee, Spouse, Child, VPAI, and all Company-provided accident insurance benefits)
- HMOs
- Optional Short Term Disability Insurance
- Long Term Disability Insurance
- Critical Illness Insurance

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Network/Claim Administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the Network/Claim Administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For Urgent Care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

To file a First Level Appeal with the Network/Claim Administrator, please complete an Application for First Level Appeal, and include with the Application all comments, documents, records, and other information relating to the denied/withheld benefit. (The Application for First Level Appeal provides information about what to include with your appeal).

The Network/Claim Administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 15 days of receipt of your First Level Appeal
- For post-service claims – within 30 days of receipt of your First Level Appeal
- For Urgent Care claims – within 72 hours of receipt of your First Level Appeal
- For Health Care Flexible Spending Account – within 30 days of receipt of your First Level Appeal

- For disability claims, within 45 days of receipt of your First Level Appeal. If The Hartford requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (The Hartford will notify you if this additional time period is needed to complete a full and fair review of your case and will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review). For disability claims, this process may also be referred to as a "Second Level Review."
- For all other claims for all benefits other than Medical, Dental, Vision , Health Care Flexible Spending Account, or Disability, within 60 days of receipt of your First Level Appeal, if the Claim Administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the EBAC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the EBAC. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the EBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the EBAC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal.)

The EBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 15-day time period
- For post-service claims, within the 30-day time period
- For Urgent Care claims, within the 72-hour time period allotted for completion of both levels of appeal
- For Health Care Flexible Spending Account– within the 30-day time period
- For disability claims, within 45 days of receipt of your First Level Appeal. If the Network/Claim Administrator requires additional time to obtain information needed to evaluate your Second

Level Appeal for disability, it may have an additional 45 days to complete your Second Level Appeal (the Network/Claim Administrator will notify you if this additional time period is needed to complete a full and fair review of your case).

- For all other claims for all benefits other than Medical, Dental, Vision, Health Care Flexible Spending Account, or Disability, within 60 days of receipt of your Second Level Appeal, if the Network/Claim Administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your Second Level Appeal (the Network/Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plan and the guidelines of the EBAC. Appointed officers of the Company are on the EBAC. In some cases, the EBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the Network/Claim Administrator, if appropriate, will be reviewed by the EBAC or its designee(s).

Rights on Appeal

In the filing of appeals under the Plan, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- Receive from the Plan Administrator or Network/Claim Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond to the new rationale

- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the Plan Administrator or Network/Claim Administrator has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is Experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for Urgent Care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
    - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

Notice of Determination

If your appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will set forth:

- Date of service, the health care Provider, the claim amount (for Medical claims)
- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for external review, and will not trigger the start of external review) (for Medical claims)

- A description of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits
- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits
- A description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures

When You are Deemed to Have Exhausted the Internal Claim and Appeal Process

If the Plan Administrator or Network/Claim Administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review (for Medical claims involving medical judgment), you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or Network/Claim Administrator that the violation was for good cause, was committed in a good faith exchange of information between you, or was due to matters beyond the Plan Administrator's or Network/Claim Administrator's control).

You may request from the Plan Administrator or Network/Claim Administrator a written explanation of the violation, and such explanation must be provided to you within 10 days. This explanation should include a specific description of the bases, if any, for its assertion that the violation should not cause the internal claim and appeal process to be deemed exhausted.

If an external reviewer (for Medical claims) or court rejects your request for immediate review because it finds that the Plan Administrator or Network/Claim Administrator met the standards for

exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or Network/Claim Administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or Network/Claim Administrator's notice.

If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

The External Review Process

After you have exhausted (of have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—and the Company-sponsored, non-grandfathered Medical and Dental Benefit Options will comply with the requirements of this external review process.

The external review process is applicable to adverse benefit determinations made under group health plans, in which the adverse benefit determination involved a medical judgment—such as:

- adverse determinations based on lack of Medical Necessity
- adverse determinations based on the assertion that the service or supply at issue was determined to be Experimental, Investigational, or Unproven in nature
- adverse determinations based on the assertion that the service or supply was cosmetic in nature
- adverse determinations based on appropriateness or type of care, appropriateness of place of care, manner of care, level of care, or whether Provider Network status could have affected availability or efficacy of treatment
- adverse determinations based on the determination of whether care constituted "emergency care" or "Urgent Care"
- adverse determination based on a plan exclusion or limitation of coverage for a particular treatment in the presence of certain medical conditions
- adverse determination based on the determination of whether care was "preventive" in nature and the care was not referenced by the US Preventive Care Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control
- adverse determination that brings into question if the benefit plan is complying with the non-quantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)

On the Plan's behalf, Blue Cross Blue Shield of Texas retains three Independent Review Organizations (IROs), as required by federal law, to conduct external reviews, and these IROs meet federal requirements as to levels of expertise, type and manner of reviews. They will conduct external reviews in compliance with the requirements of federal law.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Deadline to Bring Legal Action

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. No action may be brought more than two years after the adverse benefit determination is made on final appeal (or Second Level Appeal) with the EBAC.

If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Compliance with Privacy Regulations

Notice of Privacy Rights – Health Care Records

This notice applies to the Plan

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.

This Notice applies to health information received about you by the healthcare components of the Plan and any other group health plan for the Company serves as plan sponsor and administrator. You may receive notices about your medical information and how it is handled by other plans or insurers.

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations") and as amended by the Genetic Information Nondiscrimination Act ("GINA") and the American Recovery and Reinvestment Act ("ARRA"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices.

Note that GINA prohibits using PHI that is genetic information for underwriting purposes.

The following uses and disclosures of your PHI may be made by the Plan:

For payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverage, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf.

For treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).

For the plan's operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances.

For appointment reminders and health plan operations. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

The Plan also may use or disclose your PHI where required or permitted by law. HIPAA generally permits health plans to use or disclose PHI for the following purposes:

- where required by law;
- for public health activities;
- to report child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;
- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security; or
- to comply with Workers' Compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member of other individual involved in your care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes. You may revoke this authorization in writing at any time, provided the Plan has not yet taken action in reliance on your authorization.

Under the HIPAA privacy and security rules, the Plan is required to comply with State laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter).

Rights You May Exercise

To request restrictions on disclosures and uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form

to request restrictions on uses and disclosures of your PHI. Such requests should be made to Envoy Benefits Service Center, P.O. Box 785090, Orlando, FL 32878-5090.

To access. You have the right to request access to your PHI in the form and format requested and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Envoy Benefits Service Center, P.O. Box 785090, Orlando, FL 32878-5090. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the Envoy Benefits Service Center, P.O. Box 785090, Orlando, FL 32878-5090. You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set.

To receive an accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; or (5) as part of a limited data set.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To obtain a paper copy of this notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact **the Envoy Benefits Service Center**, P.O. Box 785090, Orlando, FL 32878-5090.

To request confidential communication. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to **the Envoy Benefits Service Center, P.O. Box 785090, Orlando, FL 32878-5090**.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your spouse call for you). Your personal representative will be required to produce evidence of his or her authority to act

on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public
- a signed authorization completed by you
- a court order of appointment of the person as the conservator or guardian of the individual, or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

If there is a material change to any provisions of this notice, the Plan will distribute a revised privacy notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts where required by HIPAA not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with Envoy Air Inc., c/o Envoy Benefits Administration Committee, 4301 Regent Blvd., MD 240, Irving, TX 75063, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. You may obtain the address of the appropriate regional office of the Office for Civil Rights from Envoy. If you would like to receive further information, you should contact Envoy, c/o EBAC, 4301 Regent Blvd., MD 240, Irving, TX 75063. This notice is effective January 1, 2016.

This Section Does Not Apply To

By law, the HIPAA Privacy rules, and the information in this section, do *not* apply to the following benefit plans:

- Disability plans (short-term and long-term disability)
- Life insurance plans, including accidental death & dismemberment (AD&D)
- Workers' compensation plans, which provide benefits for employment-related accidents and injuries
- Property and casualty insurance.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement. This organized health care arrangement is maintained by the Company and its Affiliates.

The Plan, with respect to the benefits and benefit options providing medical benefits, dental benefits, vision insurance, health care flexible spending accounts, and the HMO offered hereunder, and any other Group Health Plan for which the Company serves as Plan Administrator comprise the organized health care arrangement.

The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement for the purposes described in the regulations and in the section entitled "Notice of Privacy Rights – Health Care Records" in the "

Unless otherwise provided in the applicable insurance policy/evidence of coverage, you must file your appeal within the deadlines set forth below.

This contains appeal information and requirements

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continues to provide updated regulations, clarification and guidance on these claim procedures, the Company, as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Important Information about Health Care Provider's Appeals

As a participant in the Plan, you have the right (under federal law known as ERISA) to appeal adverse benefit determinations through the Plan's two-tiered appeal processes, as described in this section of the Guide.

However, your Network health care Providers, through their Provider contracts with the Network/Claim Administrator, also have the option to appeal adverse benefit determinations — to the extent that the adverse benefit determinations affect their benefit payments from the Network/Claim Administrator. Your Network health care Providers may appeal directly to the Network/Claim Administrator — with or without your knowledge and/or consent. These "Provider appeals" are separate and distinct from your appeal rights under ERISA, *unless the Providers specify that their Provider appeals are being filed with the Network/Claim Administrator on your behalf.*

If the Provider *specifies* in its appeal that the appeal is being filed on your behalf, the appeal *will be considered* your ERISA First Level Appeal filed with the Network/Claim Administrator. If the Provider *does not specify* in its appeal that the appeal is being filed on your behalf, the Provider's appeal *will not be considered* as your ERISA First Level Appeal. Thus, if you then decide to appeal the adverse benefit determination, you must file both the First Level and Second Level Appeals, as described in this section of the Guide (or if the appeal is an Urgent Care appeal, you must file under the "Urgent Care appeal" process, as described in this section of the Guide).

Procedures for Appealing an Adverse Benefit Determination

Appeals may be filed on adverse benefit determinations such as claim denial or reduction in benefits, eligibility/enrollment denial, partial payment or partial denial of benefits, rescission of coverage, application of a benefit penalty, or other such adverse benefit determinations. The Company, as Sponsor and Administrator of the Plan, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. For Flexible Spending Account Benefits, the First Level Appeal will be handled by the benefits administrator and the Second Level Appeal will be conducted by the EBAC.

For administrative, eligibility, and enrollment issues on any and all employee welfare benefits or plans offered, the First Level Appeal will be conducted by **the Benefits Service Center** and the Second Level Appeal will be conducted by the EBAC.

This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered process is an appeal for an Urgent Care claim – for Urgent Care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for Urgent Care claims) and must exhaust all administrative remedies to resolve any claim issues. Second Level Appeals for Urgent Care for medical treatment should be submitted to Blue Cross Blue Shield of Texas. Second Level Appeals for Urgent Care for prescription drug coverage should be submitted to Express Scripts, Inc.

With respect to adverse benefit determinations made on fully insured benefits, the appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The EBAC cannot render a decision involving fully insured benefits (except for administrative, eligibility and enrollment issues, as stated previously). The insurers and HMOs make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process, and you should contact the respective insurer or HMO for information on how to file an appeal (see “HMO Contact Information” in the *Health Maintenance Organizations (HMOs)* section.) For purposes of this paragraph, “fully-insured benefits” include the following:

- Employee Term Life Insurance (Employee, Spouse, and Child)
- Accidental Death and Dismemberment Insurance (Employee, Spouse, Child, VPAI, and all Company-provided accident insurance benefits)
- HMOs
- Optional Short Term Disability Insurance
- Long Term Disability Insurance
- Critical Illness Insurance

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Network/Claim Administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the Network/Claim Administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination.

For Urgent Care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

To file a First Level Appeal with the Network/Claim Administrator, please complete an Application for First Level Appeal, and include with the Application all comments, documents, records, and other information relating to the denied/withheld benefit. (The Application for First Level Appeal provides information about what to include with your appeal).

The Network/Claim Administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 15 days of receipt of your First Level Appeal
- For post-service claims – within 30 days of receipt of your First Level Appeal
- For Urgent Care claims – within 72 hours of receipt of your First Level Appeal
- For Health Care Flexible Spending Account – within 30 days of receipt of your First Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If The Hartford requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (The Hartford will notify you if this additional time period is needed to complete a full and fair review of your case and will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review). For disability claims, this process may also be referred to as a "Second Level Review."
- For all other claims for all benefits other than Medical, Dental, Vision , Health Care Flexible Spending Account, or Disability, within 60 days of receipt of your First Level Appeal, if the Claim Administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the EBAC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the EBAC. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the EBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the EBAC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal.)

The EBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 15-day time period
- For post-service claims, within the 30-day time period
- For Urgent Care claims, within the 72-hour time period allotted for completion of both levels of appeal
- For Health Care Flexible Spending Account– within the 30-day time period
- For disability claims, within 45 days of receipt of your First Level Appeal. If the Network/Claim Administrator requires additional time to obtain information needed to evaluate your Second Level Appeal for disability, it may have an additional 45 days to complete your Second Level Appeal (the Network/Claim Administrator will notify you if this additional time period is needed to complete a full and fair review of your case).
- For all other claims for all benefits other than Medical, Dental, Vision, Health Care Flexible Spending Account, or Disability, within 60 days of receipt of your Second Level Appeal, if the Network/Claim Administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your Second Level Appeal (the Network/Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plan and the guidelines of the EBAC. Appointed officers of the Company are on the EBAC. In some cases, the EBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the Network/Claim Administrator, if appropriate, will be reviewed by the EBAC or its designee(s).

Rights on Appeal

In the filing of appeals under the Plan, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- Receive from the Plan Administrator or Network/Claim Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond to the new rationale
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the Plan Administrator or Network/Claim Administrator has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is Experimental)

- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for Urgent Care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
    - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

Notice of Determination

If your appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will set forth:

- Date of service, the health care Provider, the claim amount (for Medical claims)
- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for external review, and will not trigger the start of external review) (for Medical claims)
- A description of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits

- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits
- A description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures

When You are Deemed to Have Exhausted the Internal Claim and Appeal Process

If the Plan Administrator or Network/Claim Administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review (for Medical claims involving medical judgment), you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or Network/Claim Administrator that the violation was for good cause, was committed in a good faith exchange of information between you, or was due to matters beyond the Plan Administrator's or Network/Claim Administrator's control).

You may request from the Plan Administrator or Network/Claim Administrator a written explanation of the violation, and such explanation must be provided to you within 10 days. This explanation should include a specific description of the bases, if any, for its assertion that the violation should not cause the internal claim and appeal process to be deemed exhausted.

If an external reviewer (for Medical claims) or court rejects your request for immediate review because it finds that the Plan Administrator or Network/Claim Administrator met the standards for exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or Network/Claim Administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or Network/Claim Administrator's notice.

If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

The External Review Process

After you have exhausted (of have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—and the Company-sponsored, non-grandfathered Medical and Dental Benefit Options will comply with the requirements of this external review process.

The external review process is applicable to adverse benefit determinations made under group health plans, in which the adverse benefit determination involved a medical judgment—such as:

- adverse determinations based on lack of Medical Necessity
- adverse determinations based on the assertion that the service or supply at issue was determined to be Experimental, Investigational, or Unproven in nature
- adverse determinations based on the assertion that the service or supply was cosmetic in nature
- adverse determinations based on appropriateness or type of care, appropriateness of place of care, manner of care, level of care, or whether Provider Network status could have affected availability or efficacy of treatment
- adverse determinations based on the determination of whether care constituted "emergency care" or "Urgent Care"
- adverse determination based on a plan exclusion or limitation of coverage for a particular treatment in the presence of certain medical conditions
- adverse determination based on the determination of whether care was "preventive" in nature and the care was not referenced by the US Preventive Care Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control
- adverse determination that brings into question if the benefit plan is complying with the non-quantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)

On the Plan's behalf, Blue Cross Blue Shield of Texas retains three Independent Review Organizations (IROs), as required by federal law, to conduct external reviews, and these IROs meet federal requirements as to levels of expertise, type and manner of reviews. They will conduct external reviews in compliance with the requirements of federal law.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Deadline to Bring Legal Action

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. No action may be brought more than two years after the adverse benefit determination is made on final appeal (or Second Level Appeal) with the EBAC.

If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Compliance with Privacy Regulations" section.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan's benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the use of the information for marketing. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, coinsurance, deductibles and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits);
- Processing utilization review, including precertification, preauthorization, concurrent review, retrospective review, care coordination or case management;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Obtaining reimbursements due to the Plan.

Health Care Operations – A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities;

- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including but not limited to:
  - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - Participant service, including the provision of data analyses for participants or the plan sponsors;
  - Resolution of internal grievances; and
  - The sale, transfer, merger, or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity.

Treatment – Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party;
- Consultation between health care providers about an individual patient; or
- The referral of a patient from one health care provider to another.

Limited data set. The Plan may disclose PHI in the form of a limited data set as provided in 45 CFR §164.514(e) provided that the disclosure is in accordance with such provisions.

Your Rights Under ERISA

Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For general information contact:

Envoy Air Benefits Service Center
P.O. Box 785090

Orlando, FL 32878-5090

1-844-843-6869

Web Address: my.envoyair.com. Select the Benefits page. You may chat live with **the Benefits Service Center** by clicking on the Chat icon on the **Benefits Service Center** page of my.envoyair.com.

For information about your claims, contact the appropriate claims processor or benefits plan administrator at the addresses and phone numbers located in "Contact Information" in the *Reference Information* section.

Reference Information

This section provides useful reference materials. It includes:

- “”
- a “Glossary,” and
- “Archives.”

Contact Information

The following table lists the names, addresses, phone numbers, and Websites (when available) for these important contacts.

For Information About:	Contact:	At:
Health and Welfare Benefits General questions, information updates, and request forms	Envoy Benefits Service Center P.O. Box 785090 Orlando, FL 32878-5090	1-844-843-6869 You can also send a secured email or “chat” to the **Benefits Service Center** from the online Benefits Service Center link on the Benefits page of my.envoyair.com.: Hours of operation are 9:00 a.m. to 6:00 p.m. CT, Monday through Friday Website: my.envoyair.com
MEDICAL COVERAGE		
PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: http://www.bcbstx.com/envoyair/
Health Maintenance Organizations (HMOs) Option	Triple-S Salud P.O. Box 363628 San Juan, PR 00936-3628	1-787-774-6060 Website: http://www.ssspr.com/
Coverage for Incapacitated Child and Special Dependents	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: http://www.bcbstx.com/envoyair/ This website can also be accessed from the Benefits page of my.envoyair.com
Predetermination of Benefits		
PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: http://www.bcbstx.com/envoyair/ This website can also be accessed from the Benefits page of my.envoyair.com

For Information About:	Contact:	At:
Pre-authorization for hospitalization		
PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-800-496-3310 Website: http://www.bcbstx.com/envoyair/ This website can also be accessed from the Benefits page of my.envoyair.com
PRESCRIPTION DRUGS (Except HMOs)		
Mail Service Prescription Drug Option (Mail Order Pharmacy Service)	Express Scripts P. O. Box 747000 Cincinnati, OH 45274-7000	1-866-544-2994 Website: http://express-scripts.com This website can also be accessed from the Benefits page of my.envoyair.com
Prescriptions – Prior Authorization	Express Scripts®	1-800-753-2851 (Member Services)
Retail Prescriptions – Phone Inquiries	Express Scripts® Member Services	1-866-544-2994
Filing Retail Prescription Claims	Express Scripts® P. O. Box 14711 Lexington, KY 40512	N/A
EMPLOYEE ASSISTANCE PROGRAM		
Employee Assistance Program	EAP	EAP Consultants, LLC 1-866-312-5018
DENTAL COVERAGE		
Dental Claims Processor	MetLife Envoy Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282	1-866-838-0875 (For eligibility, claim and provider listings) For claims tracking, to review your coverage options, or to locate a network dentist, visit the MetLife Website from the benefits page of my.envoyair.com. You will be prompted to enter a company name. Enter “Envoy.” To continue the sign-in process, enter your uniquely-created “User Name” and “Password.” If you are a first-time visitor to the site, click on “register here” under “Welcome to MyBenefits” or click the “Register Now” icon on the left. Follow the prompts to establish your account. If you have problems accessing the site, please contact MetLife’s technical help desk at 1-877-9MET-WEB (1-877-963-8932), or email: info@metlife.com.

For Information About:	Contact:	At:
VISION BENEFITS		
Vision Insurance	EyeMed	1-866-939-3633 Website: www.eyemed.com
LIFE INSURANCE		
Term Life Insurance Benefit	The Hartford Envoy Customer Unit P.O. Box 14301 Lexington, KY 40512-4301	1-866-216-0370 (For information on portability and conversion)
ACCIDENT INSURANCE		
Accidental Death & Dismemberment (AD&D) Insurance Benefit, Voluntary Personal Accident Insurance Benefit, and Other Accident Insurance Benefits	CIGNA Group Insurance (for Life Insurance Company of North America) P. O. Box 22328 Pittsburgh, PA 15222 CIGNA Secure Travel	1-800-238-2125 From U.S. and Canada: 1-800-368-7878 From all other locations: 1-202-331-1596
CRITICAL ILLNESS		
Critical Illness Insurance	American Heritage Life Insurance Company P.O. Box 43067 Jacksonville, FL 32203-3067	1-800-348-4489
DISABILITY COVERAGE		
Disability Insurance: ***Optional Short Term Disability Insurance*** ***Long Term Disability Insurance***	The Hartford Envoy Claim Unit P. O. Box 14301 Lexington, KY 40512-4301	1-866-216-0370 Website access for claims tracking and coverage information: https://www.thehartfordatwork.com/thaw/
FLEXIBLE SPENDING ACCOUNTS (FSAs)		
Health Care and Dependent Day Care FSAs	Aon Hewitt Envoy FSA P.O. Box 785040 Orlando, FL 32878-5040	Telephone: 1-844-843-6869 Fax: 888-211-9900 Website: Access the online Benefits Service Center on my.envoyair.com
LEGAL SERVICES		
Group Prepaid Legal Services	Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2507	1-800-438-6388
CONTINUATION OF COVERAGE (COBRA)		

For Information About:	Contact:	At:
Continuation of Coverage (COBRA Administrator)	Envoy Air P.O. Box 1352 Carol Stream, IL 60132-1352	1-844-843-6869
OTHER INFORMATION		
Envoy Benefits Administration Committee	EBAC Envoy Air 4301 Regent Blvd. MD 240 Irving, TX 75063	1-972-374-5227
Employee's Withholding Allowance Certificate Form W-4	Payroll Envoy Air 1821 W. Rio Salado PKWY Building E Tempe, AZ 85281	1-844-368-6947 Email to: payroll@aa.com
OTHER OPTIONS (Not Company Sponsored) The following program options are offered to eligible employees (and eligible dependents). However, Envoy Air Inc. does not sponsor these programs. For any information about these program options, please contact the sponsor(s) directly:		
Group Homeowners' and/or Automobile Insurance	Metropolitan Property & Casualty Insurance Company 477 Martinsville Road, 4th Floor Liberty Corner, NJ 07938	1-800-438-6388

Glossary

Accidental Injury

An injury caused by an outside and unforeseen traumatic force, independent of all other causes.

Alternative and/or Complementary Medicine

Diverse medical health care systems, practices, and products that are not considered to be part of conventional medicine. Alternative and/or complementary medicine have not been proven safe and effective through formal scientific studies and scientific clinical trials conducted by the National Institutes of Health (National Center for Complementary and Alternative Medicine) or that are not recognized in Reliable Evidence as safe and effective treatments for the illness or injury for which they are intended to be used. Alternative and/or complementary medicine lack proof of safety and efficacy through formal, scientific studies or scientific clinical trials conducted by the National Institutes of Health or similar organizations recognized by the National Institutes of Health. Some examples of complementary and/or alternative medicine are:

- Mind-body interventions (meditation, mental healing, creative outlet therapy etc.)
- Biological therapies (herbal therapy, naturopathic or homeopathic treatment, etc.)
- Manipulative or body-based treatment (body-work, massage, rolfing, etc.)

- Energy therapies (qi-gong, magnetic therapies, etc.).

These examples are not all inclusive, as new forms of alternative and/or complementary medicine exist and continue to develop. Other terms for complementary and/or alternative medicine include (but are not limited to) unconventional, non-conventional, unproven, and irregular medicine or health care.

Alternative Mental Health Care Centers

These centers include residential treatment centers and psychiatric day treatment facilities (see definitions in this section).

Ancillary Charges

Charges for hospital services, other than professional services, to diagnose or treat a patient. Examples include fees for x-rays, lab tests, medicines, operating rooms, and medical supplies.

Appropriate Care and Treatment (Applies to OSTD and LTD Insurance Benefits)

Medical care and treatment that is:

- Given by a Physician whose medical training and clinical specialty are appropriate for treating your disability,
- Consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research, health care coverage organizations, and governmental agencies,
- Consistent with a Physician’s diagnosis of your disability, and
- Intended to maximize your medical and functional improvement

Assignment of Benefits

You may authorize the claims processor to directly reimburse your medical service provider for your eligible expenses by requesting that the provider accepts assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim, and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment.

Bereavement Counseling

Counseling provided by a licensed counselor (usually a certified social worker, advanced clinical practitioner, or clinical psychologist) to assist the family of a dying or deceased plan participant with grieving and the psychological and interpersonal aspects of adjusting to the participant’s death.

Chemical Dependency Treatment Center

An institution that provides a program for the treatment of alcohol or other drug dependency by means of a written treatment plan that is approved and monitored by a physician. This institution must be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral
- Accredited by the Joint Commission on Accreditation of Health Care Organizations
- Licensed, certified, or approved as an alcoholism or other drug dependency treatment program or center by any state agency that has the legal authority to do so.

Chiropractic Care

Medically necessary diagnosis, treatment, or care for an injury or illness when provided by a licensed chiropractor.

Coinsurance

You pay a percentage of eligible expenses and the Medical Benefit Option pays the remaining percentage. For example, after you satisfy your deductible under the PPO 1500 Option, you pay 20% coinsurance for most covered medical services and the PPO 1500 Option pays 80%.

Common Accident

With regard to Accidental Death and Dismemberment (AD&D), this refers to the same accident or separate accidents that occur within one 24-hour period.

Company

Envoy Air Inc.

Convalescent or Skilled Nursing Facility

A licensed institution that:

- Mainly provides inpatient care and treatment for persons who are recuperating from illness or injury
- Provides care supervised by a physician
- Provides 24-hour nursing care by nurses who are supervised by a full-time registered nurse
- Keeps a daily clinical record of each patient
- Is not a place primarily for the aged or persons who are chemically dependent
- Is not an institution for rest, education, or custodial care.

Conventional Medicine

Medical health care systems, practices, and products that are proven and commonly accepted and used throughout the general medical community of medical doctors, doctors of osteopathy, and allied health professionals such as physical therapists, registered nurses, and psychologists. Conventional medicine has been determined safe and effective, and has been accepted by the National Institutes of Health, United States Food and Drug Administration, Centers for Disease Control or other federally recognized or regulated health care agencies, and has been documented by Reliable Evidence as both safe and effective for the diagnosis and/or treatment of the specific medical condition. Other terms for conventional medicine include (but are not limited to) allopathy, western, mainstream, orthodox, and regular medicine.

Copayments

You pay a specific dollar amount for certain covered services when you use network providers. For example, under the PPO 750 Option, you pay a flat dollar copayment for an office visit to your primary care physician (PCP).

Custodial Care

Care that assists the person in the normal activities of daily living and does not provide any therapeutic value in the treatment of an illness or injury.

Deductible

The amount of eligible expenses a person or family must pay before a benefit or plan will begin reimbursing eligible expenses.

Dental

Dental refers to the teeth, their supporting structures, the gums, and/or the alveolar process.

Detoxification

Twenty-four hour medically directed evaluation, care, and treatment of drug-and alcohol-addicted patients in an inpatient setting. The services are delivered under a defined set of physician-approved policies and procedures or clinical protocols.

Developmental Therapy

Therapy for impaired childhood development and maturation. Examples of developmental therapy include treatments that assist a child in walking, speech proficiency (word usage, articulation, and pronunciation), and socialization skills. Developmental therapy is not considered rehabilitative unless the function had been fully developed and then lost due to injury or illness.

Durable Medical Equipment (DME)

Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general.

The equipment must be medically necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of medical necessity from the attending physician and a written prescription must accompany the claim. DME includes, but is not limited to: prosthetics, casts, splints, braces, crutches, oxygen administration equipment, wheelchairs, hospital beds, and respirators.

Eligible Medical Expenses or Eligible Expenses

The benefit or plan covers the portion of regular, medically necessary services, supplies, care, and treatment of non-occupational injuries or illnesses up to contract rate, out-of-network reimbursement rate or usual and prevailing fee limits, when ordered by a licensed physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage.

Emergency

An injury or illness that happens suddenly and unexpectedly and could risk serious damage to your health or is life threatening if you do not get immediate care. Examples include poisoning, drug overdose, multiple trauma, uncontrolled bleeding, fracture of large bones, head injury, severe burns, loss of consciousness, and heart attacks.

Emergency Services

An appropriate medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to determine whether an emergency medical condition exists and such further medical examination and such treatment as may be required to stabilize the medical condition.

Enter-on-duty Date

The first date that you are on the U.S. payroll of the Company or an Affiliate as a regular employee.

Experimental or Investigational Service or Supply

A service, drug device, treatment, procedure, or supply is experimental or investigational if it meets any of the following conditions:

- It cannot be lawfully marketed without approval of the U. S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
- Reliable evidence shows that the drug, device, procedure, or medical treatment is the subject of ongoing phase I, II, or III clinical trials or under study (or that the consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety, or efficacy, both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis;
- The drug or device, treatment or procedure, has FDA approval, but is not being used for an indication or at a dosage that is accepted and approved by the FDA or the consensus of opinion among medical experts;
- Reliable Evidence shows that the medical service or supply is commonly and customarily recognized throughout the physicians profession as accepted medical protocol, but is not being utilized in accordance or in compliance with such accepted medical protocol and generally recognized standards of care;
- The drug, device, treatment or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure that is used with a patient informed consent document that was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function;
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;
- The treatment or procedure is less effective than conventional treatment methods; or
- The language appearing in the consent form or in the treating Hospital’s protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedure as experimental.

See the definition of “Reliable Evidence.”

Explanation of Benefits

A statement provided by the claims processor that shows how a service was covered by the plan, how much is being reimbursed, and what portion (if any) is not covered.

Fair Health

Fair Health is a relative value methodology to calculate benchmarks when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.

Free-standing Surgical Facility

An institution primarily engaged in medical care or treatment at the patient's expense and that is:

- Eligible to receive Medicare payments
- Supervised by a staff of physicians and provides nursing services during regularly scheduled operating hours
- Responsible for maintaining facilities on the premises for surgical procedures and treatment
- Not considered part of a hospital.

Home Health Care Agency

A public or private agency or organization licensed to provide home health care services in the state in which it is located.

Home Health Care

Services that are medically necessary for the care and treatment of a covered illness or injury furnished to a person at his or her residence.

Hospice Care

A coordinated plan of care that treats the terminally ill patient and family as a family unit. It provides care to meet the special needs of the family unit during the final stages of a terminal illness. Care is provided by a team of trained medical personnel, homemakers, and counselors. The hospice must meet the licensing requirements of the state or locality in which it operates.

Incapacitated Child

A child who is incapable of self-support because of a physical or mental condition and who legally lives with the employee and wholly depends on the employee for support.

Infertility Treatment or Testing

Includes medical services, supplies, and procedures for or resulting in impregnation, and testing of fertility or for hormonal imbalances which cause male or female infertility (regardless of the primary reason for the hormone therapy). Infertility treatment or testing includes, but is not limited to: all forms of in-vitro fertilizations, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer, and reversals of tubal ligations or vasectomies, drug therapy, including drug treatment for ovarian dysfunction, and infertility drugs, such as Clomid or Pergonal.

Inpatient or Hospitalization

Medical treatment or services provided at a hospital when a patient is admitted and confined, for which a room and board charge is incurred.

Life Event

Certain circumstances or changes that occur during an employee's life that qualify the employee or dependents for specific changes in coverage options.

Loss or Impairment of Speech or Hearing

Those communicative disorders generally treated by a speech pathologist, audiologist, or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and that fall within the scope of his or her license or certification.

Mammogram or Mammography

The x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube filter compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views of each breast.

Maximum Medical Benefit

The maximum medical benefit is the most a benefit or plan will pay for eligible expenses during the entire time a person is covered by the benefit or plan. The Company's self-funded Medical Benefits Options (PPO 750, PPO 1500, PPO 2500 and Out-of-Area options) do not have a lifetime medical maximum.

Medical Benefit

The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of an illness or injury. You may choose the PPO 750, PPO 1500, PPO 2500 Options, a Health Maintenance Organization (HMO), or you may waive coverage completely. If you reside in a geographic location that does not have adequate access to the PPO network, you will be eligible for the Out-of-Area option.

The Medical Benefits Options and HMOs are not offered in all locations.

Medical Necessity or Medically Necessary

A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, accidental injury, illness, or pregnancy. The benefit or plan determines medical necessity based on and consistent with standards approved by the claims processor's medical personnel. To be medically necessary, a service, supply, or hospital confinement must meet all of the following criteria:

- Ordered by a physician (although a physician's order alone does not make a service medically necessary)
- Appropriate (commonly and customarily recognized throughout the physician's profession) and required for the treatment and diagnosis of the illness, injury, or pregnancy
- Unavailable in a less intensive or more appropriate place of service, diagnosis, or treatment that could have been used instead of the service, supply, or treatment given

Either:

- Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications
- Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health for a life-threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications.

A service or supply for an illness or injury must meet the above conditions to be considered medically necessary. A service is not considered medically necessary if it is educational, experimental, or unproven in nature.

In the case of hospital confinement, the length of confinement and hospital services and supplies are considered medically necessary to the extent your Network/Claim Administrator (or HMO as applicable) determines them to be:

- Appropriate for the treatment of the illness or injury
- Not for the patient's scholastic education, vocation, or training
- Not custodial in nature.
- A determination that a service or supply is not medically necessary may apply to all or part of the service or supply.

Mental Health Disorder

A neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease or disorder of any kind listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, or any subsequent edition which constitutes the most recent edition of this manual.

Multiple Surgical Procedures

Surgical procedures performed at the same time as the primary surgical procedure, which are medically necessary but were not the primary reason for surgery.

Network

A group of physicians, hospitals, pharmacies, and other medical service providers who have agreed to provide discounted fees for their services.

Nurse

This term includes all of the following professional designations:

- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)
- Nursing services are covered only when medically necessary and the nurse is licensed by the State Board of Nursing and if the nurse is not living with you or related to you or your spouse.

Obesity

A condition in which an individual either (i) has a body weight greater than 30% above the ideal or desirable weight on standard height-weight tables, or (2) is male and has a body mass index greater than 27.8 or is female and has a body mass index of greater than 27.3. Obesity includes obesity that constitutes morbid obesity as well as all other forms of obesity.

Original Medicare

The term used by the Health Care Financing Administration to describe the coverage available under Medicare Parts A and B and D.

Outpatient

Medical treatment or services provided at a hospital or clinic for a patient who is not admitted to the hospital for an overnight stay.

Over-the-counter (OTC)

Drugs, products, and supplies that do not require a prescription by federal law.

Primary Care Physician

A network physician who specializes in family practice, general practice, gynecology, internal medicine, or pediatrics and who coordinates all of the network medical care for a participant in a PPO Option or an HMO.

Physician

A licensed practitioner of the healing arts acting within the scope of his or her license. The term does not include:

- You
- Your spouse
- A parent, child, sister, or brother of you or your spouse.

The term physician includes, but is not limited to, the following licensed individuals, listed alphabetically:

- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of osteopathy (D.O.)
- Doctor of Medicine (M.D.)
- Nurse anesthetist
- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist.

Pre-existing Condition (Applies to OSTD and LTD Insurance)

A sickness or accidental injury for which you received medical treatment, consultation, care, or service; or took prescription medication or had medications prescribed three (3) months before your insurance became effective under OSTD or LTD Insurance.

Preferred Provider Organization (PPO)

A group of physicians, hospitals, and other health care providers who have agreed to provide medical services at negotiated rates. The Medical Benefits Options' Medical Discount Program and the Dental Benefits Preferred Dentist Program are both PPOs.

Prescription

Drugs and medicines that must, by federal law, be accompanied by a physician's written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable insulin and prenatal vitamins while pregnant.

Primary Surgical Procedure

The surgery prescribed based on the primary diagnosis.

Prior Authorization for Prescriptions

Authorization by the prescription drug program administrator that a prescription drug for the treatment of a specific condition or diagnosis meets all of the medical necessity criteria.

Proof of Good Health, Statement of Health

Some benefit plans require you to provide "proof of good health" when you enroll for coverage at a later date (if you do not enroll when you are first eligible), or when you increase levels of coverage. Proof of good health (via a Personal Health Application for Life Insurance and an Enrollment Form for OSTD and LTD Insurance) is a form you must complete and return to the appropriate benefit Plan Administrator when you:+

- Increase levels of Life Insurance
- Add Long Term Disability Insurance Benefit or Optional Short Term Disability Insurance Benefit (for workgroups that offer this Plan and/or benefit)
- Coverage amounts will not increase nor will you be enrolled in these coverages until the Plan Administrator approves your Proof of good health.

If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance and Accidental Death and Dismemberment coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following your eligibility).

You may obtain a Personal Health Application from The Hartford for each benefit plan or on my.envoair.com.

Provider

The licensed individual or institution that provides medical services or supplies. Providers include physicians, hospitals, pharmacies, surgical facilities, dentists, and other covered medical or dental service and supply providers.

Psychiatric Day Treatment Facility

A mental health institution that provides treatment for individuals suffering from acute mental health disorders. The institution must:

- Be clinically supervised by a physician who is certified in psychiatry by the American Board of Psychiatry and Neurology
- Be accredited by the Program of Psychiatric Facilities of the Joint Commission on the Accreditation of Health Care Organizations
- Have a structured program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the program's treatment format. Psychiatric day treatment facility

An institution licensed and operated as set forth in the laws that apply to hospitals, which:

- Is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, either by or under the supervision of a physician
- Maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided
- Is licensed as a psychiatric hospital
- Requires that every patient be under the care of a physician
- Provides 24-hour nursing service.

The term psychiatric hospital does not include an institution, or that part of an institution, used mainly for the following:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

Regular Employee

An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, depending on the business needs of the organization or the terms of the applicable labor agreement. A regular employee is eligible for the benefits and privileges that apply to his/her workgroup or as outlined in his/her applicable labor agreement.

Reliable Evidence

Reliable evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature (including, but not limited to: AMA Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information, and National Institutes of Health)
- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment, or procedure
- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Reliable evidence does not include articles published only on the internet.

Residential Treatment Center

A facility that offers 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The center must be licensed by the state as a psychiatric residential treatment center and accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Restorative and Rehabilitative Care

Care that is expected to result in an improvement in the patient’s condition and restore reasonable function. After improvement ceases, care is considered to be maintenance and is no longer covered.

School/Educational Institution

An educational institution, including a vocational or technical school, if the student is enrolled:

- In a program leading to a degree or certificate
- On a full-time basis (generally 12 credit hours at colleges and universities).

Secondary Surgical Procedure

A surgical procedure performed at the same time as the primary surgical procedure, which is medically necessary but was not included in the primary diagnosis.

Special Dependent

A foster child or child for whom you are the legal guardian.

Summary Plan Description

In our efforts to provide you with full multi-media access to benefits information, the Company has created online versions of the Summary Plan Descriptions for our benefit plans and they are included in this Guide. The Summary Plan Descriptions also the formal legal plan documents. If there is any discrepancy between the online version and the official hard copy of this Guide, then the official hard copy, plus official notices of plan changes/updates will govern.

Subrogation

Third-party recovery (applies to Medical and Dental)

Subrogation is third party liability. Subrogation applies if the plans have paid any benefits for your injury or illness and someone else (including any insurance carrier) is, or may be, considered legally responsible.

The Plan has the right to collect payment from the third party (or its insurance carrier) for the medical treatment of your injury or illness. The Plan subrogates (substitutes) its own rights for your rights and have a lien of first priority on any recovery you receive. This means the Plan must be paid first from any settlement or judgment you receive and the Plan shall have a lien of first priority over any recovery you receive that will not be reduced by any “make whole” or similar doctrine. The Plan may assert this right to pursue recovery independently of you.

Third-party recovery (applies to OSTD Insurance)

Recovery amounts that you receive for loss of income as a result of claims filed against a third party by judgment, settlement, or otherwise, including future earnings. Such recovery amount may be an offset to your OSTD benefit.

Urgent Care

Care required because of an illness or injury that is serious and requires prompt medical attention, but is not life threatening. Examples of situations that require urgent care include high fevers, flu, cuts that may require stitches, and sprains.

Unproven Service, Supply or Treatment

Any medical or dental service, supply, or treatment that has not been proven both safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or has not been proven both safe and effective by Reliable Evidence.

See the definition of “Reliable Evidence.”

Usual and Prevailing Fee Limits/Out-of-Network Reimbursement Rates

The maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies billed by out-of-network providers. The following are the primary factors considered when determining if a charge is within the usual and prevailing fee limits:

- The range and complexity of the services provided
- The typical charges in the geographic area where the service or supply is rendered/provided and other geographic areas with similar medical cost experience.

The Plan Administrator utilizes a database of charge information about healthcare procedures and services, and this database is reviewed, managed, and monitored by FairHealth. Information about FairHealth and its work on this database is available at www.fairhealthus.org. Information from this FairHealth database is utilized by the Company's medical administrators in determining the eligible expense for services provided by out-of-network, non-contracting, non-hospital providers under the Out-of-Area option.

The Plan Administrator utilizes the Medicare allowable rates to determine the reimbursement rate for out-of-network, non-contracting hospitals. For out-of-network, non-contracting hospital charges, the Plan Administrator considers usual and prevailing to be equal to 200% of the Medicare allowable for the same type of hospital charges. Professional fees billed by out-of-network physicians are limited to 50% of Fair Health values.

The usual and prevailing fee limits can also be impacted by number of services or procedures you receive during one medical treatment. Under the Plan, when the claims processor reviews a claim for usual and prevailing fees, it looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (called "coding fragmentation" or "unbundling") usually results in higher physician charges than if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

Archives

Prior versions of your Employee Benefits Guide (EBG) are available athttp://www.envoyair.com/home/benefits/.