Summary Plan Description

All employees

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United Airlines Consolidated Welfare Benefit Plan

General Information

Section 1. Introduction

This Summary Plan Description ("SPD") is designed to provide you with a description of the United Airlines Consolidated Welfare Benefit Plan (the "Plan"), sponsored by United Airlines, Inc. (the "Company"). Under federal law, the Company is legally required to provide this SPD to you and other eligible participants under the Plan.

Detailed information regarding the Plan's benefits available to your employee group can be found by reviewing the following resources:

- This SPD, which includes:
  - Benefit Program Chapters (applicable to all employee groups)
  - Schedule of Benefits attached as an Addendum (applicable to your employee group)
  - *Contact Information Sheet* attached as an Addendum, which shows the addresses, phone numbers, websites, and other information for the Plan's claims administrators, insurance companies, and United Airlines Benefits Center ("UABC")
- The Plan's Website found at flyingtogether.ual.com > Employee Services > Benefits (for single sign-on) or at www.ybr.com/united, which includes:
  - *Frequently Asked Questions* regarding the benefit programs offered under the Plan
  - Additional detailed schedules of benefits for the various benefit programs under the Plan
  - Electronic copies of the most recent SPD and attachments, including the most recently-updated *Contact Information Sheet*
- The Plan's governing documents and insurance policies/certificates, copies of which can be obtained by contacting the United Airlines Employee Service Center.

About the Plan

The Plan is comprised of various types of Benefit Programs, summarized as follows (each of which is described in separate chapters of this SPD):

- Medical Program
- Dental Program
- Vision Program
- Flexible Spending Program
- Long Term Disability Benefit Program
- Life and Accident Insurance Program
- Benefits After Retirement

Within each Benefit Program, the coverage options may vary by employee group. See the Schedule of Benefits for your employee group attached to this SPD as an Addendum. In addition, if you are a domestic employee on international assignment, you may have alternative coverage options available to you which will be communicated to you as part of the enrollment process.

Type of Plan

The Plan is designed and administered as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"). In accordance with Code Section 125, a participant who is actively employed by the Company may pay for certain benefits offered under the Plan on a pre-tax basis through salary reductions. In addition, a participant may elect to contribute a portion of his salary to the Flexible Spending Program, also on a pre-tax basis.

Coordination with Plan Documents and Additional Information

Unless otherwise mentioned, this SPD reflects the terms of the Plan that are applicable to individuals who are covered under the Plan on January 1, 2017. Please read this entire SPD carefully so you will understand the benefits offered by the Plan.

This SPD is a simplified description of the major features of the Plan, including each of the Benefit Programs offered under the Plan. Special situations which affect a limited number of employees may not be covered in this SPD. Each of the benefits described in this SPD is governed solely by the terms of a separate legal document or contract. If there is a conflict between this SPD and the Plan documents controlling the operation of the Plan, the Plan documents will govern. You may obtain a copy of the documents comprising the Plan upon written request to the Employee Service Center, or you can refer to copies of each such document on file with the Employee Service Center.

Section 2. Participation

Benefits described in this SPD are generally available to regular full-time and part-time employees on the U.S. payroll. Any specific eligibility requirements are discussed in the chapters of the SPD describing each type of benefit or in the Schedule of Benefits attached to this SPD as an Addendum.

Enrolling for Coverage

You may enroll within the first forty-five (45) days of employment or eligibility (or during a subsequent annual enrollment period or due to qualifying family or work status changes):

- via the Internet at flyingtogether.ual.com > Employee Services > Benefits (for single sign-on) or at www.ybr.com/united; or
- by calling the UABC.

You can find the current cost of coverage, and additional information needed to complete enrollment, through the sources listed above.

During the Annual Enrollment Period, which is usually during the fourth calendar quarter of the Plan Year, you will be provided with an opportunity to change your coverage, and that of your dependents, effective as of the following January 1. **You must re-enroll each year you wish to participate in the Flexible Spending Program.**

Reemployment

If you are rehired within 30 days after your employment terminates, the coverages in effect immediately before your termination will be reinstated. If you are rehired more than 30 days after your employment terminates, you have a choice as to whether or not to resume coverage, and you may make new coverage elections.

Dependent
For all Benefit Programs other than the Flexible Spending Program, your dependents include your spouse or qualified domestic partner and any dependent children, as defined below.

Please see the Flexible Spending Program Chapter for descriptions of individuals on whose behalf you may incur expenses that are reimbursable under the Health Care FSA or Dependent Care FSA. Supporting documentation must be provided when requested.

Spouse
Your spouse is the person who is your spouse for federal tax purposes pursuant to applicable Internal Revenue Service guidance; provided, however, that a spouse shall not include an individual legally separated from you pursuant to a divorce or separate maintenance decree.

Dependent Child
Your eligible dependent children include your child younger than age 26.

In addition, your eligible dependent children include your child who is age 26 or older, who is unmarried and primarily dependent (over 50%) on you for support and maintenance, and who has been continuously incapable of self-sustaining employment because of a mental or physical disability since before age 26 (even if you did not have coverage under the Plan at that time). Self-sustaining employment means that your child is able to work on a full-time basis (typically 40 hours per week) and earns at least the federal minimum hourly wage. Such child will cease, forever, to be a dependent child on the first date such child is no longer primarily dependent on you for support or is able to earn a living. You must provide the UABC with satisfactory proof of your dependent child's disability within 60 days before the date the child attains age 26 and at any later time requested. If proof is requested by the UABC and is not furnished within 60 days of such request, such child will cease to be considered a dependent child effective as of such 60th day.

The term "child" means: (a) your biological child (or your qualified domestic partner's biological child); (b) your stepchild; (c) any child legally adopted by you (or by your qualified domestic partner) (including a child placed in custody for such an adoption), and (d) any other individual for whom you (or your spouse or qualified domestic partner) is a court-appointed permanent legal guardian.

A dependent child who is in the military service may be ineligible for certain benefits in accordance with the applicable insurance policy.

Qualified Domestic Partner
Your qualified domestic partner is your same or opposite-sex domestic partner for whom you have filed the required proof of domestic partnership with the Company and with whom your domestic partnership has not terminated. Company-approved forms are available by calling the UABC.
If your qualified domestic partner is covered as a dependent (and is not an employee of the Company), then the value of the coverage (for medical and dental coverage, based on the Company's cost of coverage for the "1 Adult" coverage tier) must be reported as additional income to you and applicable taxes are withheld from your pay.

Please note, some HMOs or DHMOs may have their own rules regarding coverage for domestic partners (including not providing such coverage at all). The HMO or DHMO is the final authority in determining eligibility for domestic partners under an HMO or DHMO option.

Team Eligibility
If you and your spouse or qualified domestic partner are both employees of the Company, you are referred to as a "team" and special eligibility and coverage provisions apply to you under the Medical and Dental Programs. Please contact the UABC for additional information.

Qualifying Family or Work Status Change Events

Your elections under the Medical, Dental and Vision Programs and the Flexible Spending Program are valid for an entire year and you will generally not be allowed to change your elections until the next enrollment period. This is because the IRS requires that you commit to participating in such a plan or program for the entire year in order to receive the tax advantage of paying for your premiums for that plan or program with pre-tax dollars.

However, the IRS does provide exceptions that allow you to change your elections mid-year. You can change your elections under the Medical, Dental, Vision and/or the Flexible Spending Programs if you experience a change in status or if you experience a special event that entitles you to make new elections under such plan(s) or program. Except as provided otherwise, a mid-year election change will take effect on the first day of the month following the applicable change in status or other special event.

The IRS currently defines a "change in status" as one of the following events:

- A change in your marital status, including your marriage, legal separation, divorce or annulment;
- The birth, adoption, and placement for adoption of your dependent child;
- The death of your dependent;
- The commencement or termination of employment by you or your dependent;
- A change in your or your dependent's employment status, including a strike or lockout, a layoff, a switch between part-time and full-time employment, or the commencement or return from an unpaid or significantly reduced paid leave of absence;
- Any other change in your or your dependent's employment status that affects eligibility to participate in one or more benefit plans in which they are enrolled for the Plan Year;
- Your and/or your dependent's Medicaid or State Children's Health Insurance Program coverage is terminated due to a loss of eligibility;
- You and/or your dependent become eligible for a premium assistance subsidy under Medicaid or a State Children's Health Insurance Program;
- Your hours of service are reduced so that you are expected to average less than 30 hours of service per week, even if the reduction does not affect your eligibility for coverage under the Medical Program; or
- You are participating under the Medical Program and cease your coverage to instead purchase medical coverage through a competitive marketplace established under the Patient Protection and Affordable Care Act without that resulting either in a period of duplicate coverage under the Medical Program and the coverage purchased through a marketplace or in a period of no coverage.

Generally, you must notify the UABC within 45 days after one of the above change in status events if you and/or your dependents become eligible for group health plan coverage and you wish to add such individual(s) or if you wish to change the level of coverage previously elected for yourself and/or your dependents.

However, if you and/or your dependents terminate Medicaid or State Children's Health Insurance Program coverage due to loss of eligibility, or become eligible for a premium assistance subsidy under those programs, then you must notify the UABC of your desire to change coverage within 60 days after the corresponding change in status event.

In addition, you must notify the UABC within 60 days after one of the above change in status events if a dependent becomes ineligible for group health plan coverage, or else such individual will lose his or her eligibility for COBRA continuation coverage. Please note, however, that any change in your elections must be consistent with the change in status that you experienced. The Plan Administrator, in its sole discretion, will determine whether your elections are consistent with your change in status.

The Plan Administrator may require you to provide proof of your change in status, such as birth certificates, divorce decrees, etc.

In addition to the changes in status described above, you may also have an opportunity to immediately change your elections under the Medical, Dental and/or Vision Programs (including elections not to participate) upon the occurrence of one of the following events:

(1) **HIPAA special enrollment**. You acquire special enrollment rights in the Medical, Dental and Vision Programs due to your loss of other insurance coverage or the addition of a dependent, as provided under the Health Insurance Portability and Accountability Act ("HIPAA"). You may enroll yourself and your dependents for medical, dental and/or vision coverage, even if you were not previously enrolled, within 45 days after the following special enrollment events:

- You declined medical, dental and/or vision coverage because you or your dependent had other coverage and the other coverage ends because:

  -- You or your dependent are no longer eligible for such coverage (whether such coverage was provided through another employer, private insurance or otherwise);

  -- You or your dependent exhaust COBRA coverage under another employer's group health plan (other than due to a failure to pay contributions or cause); or

  -- Company contributions toward the other group health plan coverage terminate.

  If you timely enroll, coverage will take effect on the first day after the event that causes you to lose coverage.

- You acquire a dependent as a result of a marriage, birth, adoption or placement for adoption. If you timely enroll, coverage will take effect on the date you acquired the new dependent.

- Based on the eligibility criteria for coverage as a dependent child under the Medical, Dental and Vision Programs, your child becomes (or is required to become) eligible for Medical, Dental and Vision Program coverage as a dependent.

If you do not request the change within the applicable 45 day special enrollment period, you lose special enrollment rights for that event.

Please note, these special enrollment rights permit you to enroll only yourself and your affected dependents. If you elect to change your Medical, Dental and/or Vision Program coverage under these special enrollment rights, you may also elect to change your Health Care FSA election for the applicable period.

(2) **QMCSO**. The Plan Administrator receives a notice or an order that qualifies as a "qualified medical child support order" that requires you to pay for dependent coverage that is available through the Plan. You may change your group health plan elections at any time if required to do so by a QMCSO. This change will be effective on the first day of the month following the QMCSO's effective date or the date of notification, whichever is later. For a copy of the Plan's QMCSO procedures, please contact the Employee Service Center.

(3) **Medicare or Medicaid.** You or your dependent (including your spouse) become enrolled in, or lose, medical coverage under Medicare or Medicaid (other than under a program solely providing pediatric vaccinations). You may change your Medical Program election under the Plan if your Medicare or Medicaid entitlement changes. This change will be effective on the first day of the month following the effective date of your Medicare or Medicaid coverage or your date of notification, whichever is later. Please note, you may not change your Health Care FSA election upon becoming enrolled in, or losing, Medicare or Medicaid coverage.

(4) **Other Reasons.**

- Substantial change in the premium rate for benefits. You may change a Medical, Dental, or Vision Program (but not the Health Care FSA) election within 45 days following the event.
- Significant reduction of coverage that is not a loss of coverage.
- Significant reduction of coverage with a loss of coverage.
- Addition or improvement of benefit package option providing similar coverage.
- Coverage change of another employer plan.

In addition, you may change your Dependent Care FSA election mid-year if the cost of dependent care substantially increases (unless your dependent care provider is a relative), or if you change dependent care providers mid-year and your new provider charges substantially more or less than your previous provider. Such an election change must be made within 45 days of the corresponding change in the cost of dependent care.

As with a change in status, any change in your Plan elections that you are allowed to make as a result of one of the above events must be consistent with the event. The Plan Administrator, in its sole discretion, will determine whether you are eligible to change your election and whether the change is consistent with your situation.

How to Change Your Elections: If you experience a change in status or other event described above and you want to change your Plan elections as a result, contact the UABC as soon as possible. **You must enroll within the applicable period described above with respect to each event permitting an election change**. Any change in your contributions will become effective with the earliest possible pay period after your election change takes effect.

Deleting Dependents

If one of your dependents ceases to be eligible for coverage under the Medical, Dental or Vision Programs, within 60 days after the date your dependent becomes ineligible you must notify the UABC. This includes situations where:

- Your dependent child loses eligibility;
- You and your spouse divorce; or
- Your qualified domestic partnership is terminated.

If the Company determines that your dependent is no longer eligible for coverage, he or she will immediately be removed from coverage as of the ineligibility date. You may also be held liable for reimbursing the Plan for any expenses paid by the Plan on your dependent’s behalf after he or she was no longer eligible for coverage.

Section 3. When Coverage Ends

When Coverage Ends for You

Please note, this section addresses termination of coverage for the Medical Program, Dental Program, Vision Program, and Flexible Spending Program only. Information regarding termination of other coverages can be found in the SPD chapters describing those coverages.

Your coverage under the Medical Program, Dental Program, Vision Program and Flexible Spending Program ends on the last day of the calendar month during which the first of the following occurs: (1) you are no longer eligible, (2) your last day of active employment with the Company (unless you are on a Company-approved leave with benefits or special leave to retirement, you are a non-striking employee who has ceased work because of a work stoppage by striking employees, or you are a Flight Attendant who is on voluntary furlough), (3) you are laid off, (4) if you fail to timely pay the required contribution for coverage (subject to any applicable grace period and/or termination notice), the last month you are fully paid through, or (5) the Plan (or any Benefit Program covering you) terminates.

When Coverage Ends for Your Dependent

Unless your dependent is eligible for, and elects to receive, coverage in the event of your death (as described below), your dependent's coverage ends on the last day of the calendar month during which the first of the following occurs: (1) your coverage ends, (2) you terminate your dependent's coverage, (3) your dependent is no longer eligible for coverage, (4) you do not make the required contribution for coverage, or (5) the Plan (or any Benefit Program covering you) terminates.

Section 4. Continuation of Coverage

COBRA Continuation Coverage Rights

The Consolidated Omnibus Budget Reconciliation Act of 1986, as amended ("COBRA"), provides you and your covered dependents the right to continue your Medical, Dental and Vision Program, and Health Care FSA coverage for a period of time if coverage is lost because of a "qualifying event." Health Care FSA coverage is only available for the remainder of the Plan Year in which coverage is lost.

Please note, if you are entitled to Medicare coverage, you should consider the benefits available to you under Medicare before electing to continue your Medical Program coverage under COBRA.

Although COBRA continuation rights do not apply to a covered dependent who is a qualified domestic partner, the Medical Program offers continuation coverage similar to COBRA continuation coverage for a qualified domestic partner, but only if the qualified domestic partner would otherwise lose his or her coverage due to your death, termination of the domestic partnership or your termination of employment. In either case, coverage is continued for the qualified domestic partner for only up to 18 months.

Qualifying Events

For employees, the qualifying events are: (1) a termination of employment, or (2) a loss of eligibility for coverage due to a reduction in scheduled work hours.

For dependents, the qualifying events are: (1) the employee's termination of employment, (2) the employee's loss of eligibility for coverage due to a reduction in scheduled work hours, (3) the employee's death, (4) the employee's divorce or legal separation or termination of his or her domestic partnership, (5) a dependent child's ceasing to qualify as an eligible dependent under the Plan, or (6) the employee's termination of coverage as a result of becoming covered by Medicare.

Initial COBRA Notice

For additional information, please see the initial COBRA notice provided to you separately.

Section 5. Claims and Appeal Procedures

Claims and Appeals for Benefits

To obtain your benefits under the Plan, you may have to file a claim. The benefits available to you under the Plan are described in separate chapters of this SPD, each of which explains the claims and appeals procedures applicable to the benefit described therein. You may contact the Claims Administrator, insurance company or HMO/DHMO for the relevant benefit to obtain the proper claim forms or for any additional information you need.

Claims Relating to Eligibility to Participate or Enrollment

The Plan provides benefits only to those individuals who meet the Plan's eligibility criteria. To file a claim relating to your eligibility to participate in the Plan or your enrollment, you must submit your claim in writing, describing the nature of your claim and providing any information supporting your claim. The claim form may be obtained by contacting the UABC.

If your claim is denied, Benefit Administration will provide you with written notice of the decision on your claim within 90 days after the claim is received. Under special circumstances, the time for making a decision may be extended an additional 90 days, provided that you are notified of the extension.

Appealing an Eligibility Claim Denial

If you or your dependent file an eligibility claim and it is denied, you may appeal the denial to the United Welfare Benefit Appeals Committee within 180 days after the date the claimant receives notice of the adverse decision. Your appeal must be in writing and should include an explanation of why you believe the denial was issued in error. You must mail your appeal to the address stated in the denial letter provided to you by Benefit Administration.

The following is a sample list of reasons that a claim may be denied on the basis of eligibility:

- You or your dependent are no longer covered under the Benefit Program because you or your dependent failed to pay the required contributions by the due date.
- You or your dependent are not covered under the Benefit Program because you failed to enroll yourself or your dependent in the Benefit Program within the requisite time period.
- An individual you attempted to add as a dependent failed to meet the eligibility requirements of the Plan or Benefit Program.

The United Welfare Benefit Appeals Committee will provide you with its decision regarding your appeal within 60 days of the date that your appeal is received, unless there are special circumstances requiring an extension of up to 60 additional days, in which case, you will be notified of the extension.

If, after reviewing your appeal, the United Welfare Benefit Appeals Committee upholds the denial of your eligibility claim, you will be notified of the specific reason(s) for denial. You may obtain copies of any relevant documents, free of charge.

If the United Welfare Benefit Appeals Committee decides that your coverage under one or more Benefit Programs may be restored retroactively, the applicable premiums for the restored period (up to the next occurring billing date, if applicable) will be deducted from your next paycheck after you are notified of the decision. If you are billed directly for your Benefit Program premiums, all premiums due must be submitted to reinstate benefits. If you were previously enrolled in an HMO or DHMO, your reinstatement will be subject to the HMO's or DHMO's retroactive reinstatement rules/policy.

Right to Reimbursement

The Plan has a right of reimbursement when the Plan has paid health care expenses for you or your dependents and those expenses are later recovered from a third party who is responsible for paying those expenses. The Plan's recovery is primary to all expenses, including attorney's fees, but is limited to the amount of the award or the amount paid by the Plan, whichever is smaller. Please note, certain

Benefit Programs may set forth additional terms and conditions related to the Plan's right to reimbursement.

Legal Action

Unless otherwise stated in the applicable SPD Chapter, with respect to all other Benefit Programs under the Plan, legal action may not be commenced more than 12 months after a claim was submitted or was required to be submitted. Also, you may not file a legal action until you have exhausted your claim and appeal rights for the benefit claim. If you want to take legal action for any reason related to a benefit claim, you may serve legal process on the Company at the address found below. Legal process may also be served on the Plan Administrator.

Section 6. Plan Information

Plan Name and Number

United Airlines Consolidated Welfare Benefit Plan; 540

Plan Year

Calendar year beginning on January 1st and ending on December 31st

Plan Sponsor

United Airlines, Inc.
233 S. Wacker Drive
25th Floor (WHQHR)
Chicago, IL 60606

The Employer Identification Number assigned by the IRS to the Company is 74-2099724.

Plan Administrator

Plan Administrator
c/o Employee Service Center – WHQHR
P.O. Box 06649
Chicago, IL 60606-0649

The Plan Administrator has discretionary power and authority to interpret, apply and enforce all provisions of the Plan document, as set forth in the Plan document.

Funding and Administration of the Plan

Benefits under the Plan are funded through both Company contributions and your contributions. Benefits are paid through a combination of self-insured arrangements (which may include one or more trusts maintained by the Company) and contracts with insurance companies. For additional information regarding how benefits are funded and paid under the Plan, please contact the Employee Service Center.

Amendment and Termination of the Plan

While the Company expects to continue the Plan indefinitely, the Company has reserved the right to modify, reduce, amend or terminate all or any part of the Plan at any time and for any reason. Some of the reasons for changing or terminating could include, but are not limited to, the following: (1) dissolution, merger, consolidation, reorganization, sale, or bankruptcy of the Company or part of the Company, (2) disqualification by the IRS of a trust funding benefits under the Plan, (3) changes in the laws, or (4) change in the goals, business plans, or economic circumstances of the Company.

No Employment Rights

Plan participation does not give you any rights to continuing employment with the Company.

ERISA Statement of Rights

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions. Contact the Employee Service Center to schedule an appointment to examine any such documents.

- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. 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 financial report.

- Continue health care coverage for yourself, spouse or other dependents if there is a loss of coverage under a group health plan as a result of a qualifying event. You or your dependent may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

- Be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date for coverage under another plan.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in 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 Plan Administrator. If you have a claim for benefits which is denied (through the appeal procedure) or ignored, in whole or part, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a 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 if, for example, it finds your claim is frivolous.

If you have any questions about the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Misstatements of Facts

The submission of a claim is a certification that the information is true, correct and complete. Falsified claims are void and falsifying a claim in any manner will result in a denial of benefits. The Claims Administrator retains the right to recover any payments made on the basis of a falsified claim. Recovery may be made from you, any person receiving the payment, or any individual for whom the expenses were incurred. You also may be subject to disciplinary action, up to and including termination of employment.

Overpayments

The Claims Administrator has the right to recover any overpayment from the person to whom such overpayment was made, from any person who received such overpayment and from any person benefiting from such overpayment. The Claims Administrator may reduce any benefits payable for any employee or dependent by the amount of any outstanding overpayment.

Medical Program

Section 1. Introduction

The Medical Program offers multiple coverage options. Depending on your employee group, it may include one or more preferred provider organization (“PPO”) options, exclusive provider organization (“EPO”) options, and high-deductible health plan (“HDHP”) options. **The key provisions of each coverage option available to you are set forth in the Schedule of Benefits attached as an Addendum to this SPD.** In addition, one or more health maintenance organization (“HMO”) options may be available to you. Additional detailed information on each coverage option, including each HMO option, can be found on the Plan Website.

Section 2. Eligibility and Coverage

Initial Eligibility

As a regular full-time or part-time employee, you and your eligible dependents are eligible to participate in the Medical Program when you satisfy the service requirements described in the “Participation” section in the General Information Chapter.

Dependent Eligibility

Your dependent is eligible for coverage on the same date you become eligible or, if later, on the day he or she first becomes your dependent. In order for your dependent to receive coverage, you must enroll him or her within 45 days of the date he or she first becomes eligible. Coverage will be retroactive to the date of eligibility (marriage, domestic partnership, birth or adoption). Otherwise, you may not enroll your dependent until the next annual enrollment period.

Identification Card

When you enroll in a coverage option, you will receive an identification card for you and your covered dependents. This card must be presented to the hospital, medical provider and/or pharmacy when you or a dependent receives medical treatment. Presentation of the identification card does not guarantee that benefits will be paid by the Plan.

Section 3. HMO Coverage Options

Depending on where you live, you may be eligible to elect an HMO option in lieu of other coverage options. Additional rules and a description of covered expenses and exclusions are provided by the applicable HMO in a separate booklet. In all cases, your rights and benefits and those of your dependents are governed by the terms and conditions of the Plan and the applicable HMO documents. For additional information regarding HMO coverage options that may be available to you, please see the Plan Website.

Section 4. Paying for Services

Participant Contributions

The required contribution for each month of coverage under the Medical Program is based on a four-tier structure of coverage:

- 1 Adult (*Employee or Surviving Spouse or Surviving Domestic Partner*);
- 1 Adult and Dependent Child(ren) (*Employee plus Dependent Child(ren) or Surviving Spouse or Surviving Domestic Partner plus Dependent Child(ren)*);
- 2 Adults (*Employee plus Spouse or Domestic Partner*); and

- Family (*Employee plus Spouse and Dependent Child(ren) or Employee plus Domestic Partner and Dependent Child(ren)*).

Your monthly contribution will be communicated to you in connection with initial or annual open enrollment. The monthly contribution amount varies by employee group and coverage option. In addition, you may contact the UABC to obtain your monthly contribution information.

If your spouse or domestic partner has alternative coverage under another employer plan, you may be subject to a higher monthly contribution. The Company may offer a reduction to your monthly contribution to encourage you to participate in one or more wellness or disease management programs.

Section 5. Exclusive Provider or Preferred Provider Networks

Some Medical Program coverage options have different "in-network" and "out-of-network" benefit levels based on whether you access a specific provider network. You may obtain information about which hospitals and physicians in your area are participants in the networks for your coverage options by calling the Claims Administrator for the coverage option or by accessing the Claims Administrator's website.

Section 6. Managed Care

Pre-Certification and Pre-Notification of Hospital Confinements

As soon as your physician recommends any hospitalization or if you require inpatient mental health, substance abuse or chemical dependency treatment, you, your physician or a family member must notify the applicable Claims Administrator in order to qualify for full benefits. You must provide the Claims Administrator with any required information.

No pre-certification/pre-notification is required for an emergency hospital confinement, though you should notify the Claims Administrator if you are admitted to a hospital. Please note, pre-certification/pre-notification is not a guarantee of coverage, and is still subject to review for medical necessity. For specific details about the pre-certification/pre-notification requirements for each coverage option, contact the Claims Administrator identified in the Contact Information Sheet attached to this SPD.

Hospitalization for Childbirth

If your physician prescribes a hospital stay for you and your newborn child not exceeding 48 hours following a vaginal delivery or not exceeding 96 hours following a cesarean section, you are not required to obtain pre-certification for the hospital stay. If your physician prescribes a longer hospital stay, or if complications develop that require a longer stay, you, a family member, or your physician must call the Claims Administrator of your coverage option to have the hospital stay reviewed to qualify for full benefits.

Under federal law, group health plans (such as the Medical Program) may not (i) restrict benefits for any hospital stay in connection with childbirth for the mother and newborn child to less than 48 hours following normal vaginal delivery or less than 96 hours following a cesarean section, or (ii) require the health care provider to obtain authorization from the Plan (including the Medical Program) or insurer to prescribe a length of stay not longer than such periods, or (iii) set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Section 7. Covered Expenses and Exclusions

Generally

Each coverage option has a specific schedule for covered expenses and exclusions, as well as the list of preventive services that are covered at 100%. The term "covered expenses" means the medical expenses incurred by an employee or dependent that are recognized as payable under the applicable coverage option, subject to certain exclusions. See the detailed schedules of benefits found on the Plan

Website. Federal law requires that certain minimum "essential health benefits" be provided in accordance with one or more coverage benchmarks. Please contact the Plan Administrator for additional information regarding the benchmark(s) used under the Plan.

Emergency Services

In addition, each coverage option also provides various emergency medical care services for the initial outpatient treatment, including related diagnostic services, of an injury or sickness displaying itself by acute symptoms of sufficient severity (including severe pain, convulsions, or difficulty breathing) that a prudent layperson possessing average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of a bodily organ or part. See the detailed schedules of benefits found on the Plan Website.

Medical Necessity

The Plan Administrator or its delegate makes all determinations whether an expense is medically necessary under a coverage option in accordance with the standards and procedures applicable to such coverage option.

Section 8. Maintenance of Benefits and Coordination of Benefits

The Medical Program contains maintenance of benefits provisions to coordinate coverage between this Plan and any other under which you and/or any dependents have coverage. This means that the Medical Program works with other group plans (including Medicare and non-U.S. national health insurance) to provide you with benefits up to the benefit amount provided by the higher plan. For example, if this Plan is the secondary plan and the primary plan covers a claim at a level which is less than the coverage under the Plan, the Plan will only pay the portion of the claim necessary to bring the total coverage up to the level provided under the Plan. Please consult the Plan's governing documents for additional information.

Coordination with Medicare

You and your dependents generally become eligible for Medicare at age 65. Medicare is generally considered secondary for employees actively at work and their dependents who are eligible for Medicare coverage (some exceptions include certain situations when the dependent is a domestic partner and certain cases of renal failure). Medicare is generally considered primary for employees not actively at work and their dependents who are eligible for Medicare coverage. If, for example, you are retired and eligible for Medicare Part B, then the Plan may treat you as covered by Medicare Part B even if you fail to enroll for coverage. Medicare is also considered primary for certain disabled employees who become eligible for Social Security disability benefits before age 65. If you are eligible for Medicare Part A on account of your disability and you are receiving disability benefits from the Company for more than six months, or receiving Social Security disability benefits, then the Plan may treat you as covered by Medicare Part A and B even if you fail to enroll for Part B coverage. Certain exceptions may apply to employee groups covered by collective bargaining agreements.

Please notify the UABC once you start Medicare benefits. See the *Frequently Asked Questions* on the Plan Website for additional information.

If Medicare is primary for you and/or a dependent, when submitting a claim to the Medical Program, please be sure to submit any Explanation of Benefits (EOB) you receive from Medicare. The combination of what Medicare pays and what the Medical Program pays may not exceed what the Medical Program alone would have paid.

Coordination with TRICARE

TRICARE is government sponsored health care coverage for military personnel on active duty. The coordination of your benefits under TRICARE works differently from the rules governing coordination with

another employer plan or Medicare. If you or your dependents are receiving benefits under TRICARE, generally TRICARE will be the secondary payer with respect to any benefit offered under the Plan. For more information on how TRICARE coordinates with Medical Program and Dental Program coverage, please consult your TRICARE handbook or contact the Employee Service Center.

Section 9. Prescription Drugs

The coverage options under the Medical Program also provide various prescription drug benefits. The Claims Administrator offers service to you through its network of retail pharmacies and a mail order service which will fill your long-term or maintenance drug prescriptions by mail order. Participation in home delivery (the mail order pharmacy) may not be available for a covered employee or dependent whose coverage under the Medical Program is considered secondary to another plan, as described in the "Maintenance of Benefits and Coordination of Benefits" section above.

Please note, self-injectable drugs must be filled through the Prescription Drug Program, even if they are injected by a physician or other health care professional.

For additional information regarding the prescription drug benefits available to you under each coverage option, please see the Schedule of Benefits attached as an Addendum to this SPD.

Section 10. Claims and Appeals Procedures

This section describes the procedures for submitting and, if necessary, appealing a claim for benefits under a coverage option. However, please see the *Frequently Asked Questions* on the Plan Website for a description of the submission procedures for prescription drug claims.

Claims Relating to Eligibility to Participate or Enrollment

If you inquire as to your eligibility for Medical Program coverage independent of a claim for benefits, your inquiry will be treated as an eligibility claim and will be decided in accordance with separate claims and appeals procedures described in the section entitled "Claims Relating to Eligibility to Participate or Enrollment" in the General Information Chapter.

Please note, a claim for medical services or treatment may be denied because you or your dependent did not satisfy the Plan's eligibility criteria. Such a claim (and subsequent appeal, if any) will be decided in accordance with the procedures described below for claims relating to benefits.

Claims Relating to Medical Services, Treatments, and Other Benefits

The applicable Claims Administrator makes determinations on behalf of the Plan as to whether or not a claim for medical services, treatments, etc. is payable under the terms of the Plan. The Claims Administrator provides only claims administration services. Medical benefits under this Plan are not in any manner insured, guaranteed or otherwise payable by the Claims Administrator.

If you have not already paid the provider, the Claims Administrator may pay the provider directly. Otherwise, you will receive the payment for the portion of the claim payable by the Plan.

The Claims Administrator may determine that a claim is not payable (or a penalty applies) for a number of reasons, such as the following:

- The claim was submitted after the applicable deadline.
- The charges were incurred for a hospital stay that was not pre-certified.
- Charges were submitted for services relating to cosmetic surgery.
- The services are not considered to be medically necessary, and are not otherwise determined to be a Covered Expense under your coverage option.

Special rules may apply if you are unable to file a claim within the applicable deadlines or if you are legally incapacitated. Please contact the Claims Administrator for more information.

A "claim" is a request for a Plan benefit. A "claimant" is the individual who is making a request for Plan benefits. A "representative" can make a claim or appeal a claim on the claimant's behalf. The Plan will recognize a health care professional with knowledge of the claimant's medical condition as the claimant's representative for purposes of the initial submission of a claim and for urgent claims, unless the claimant provides written direction otherwise. A parent or guardian may file claims, appeals and information requests on behalf of a dependent child. However, in all other situations, a participant must notify the Medical Program in writing if the participant has appointed an individual to represent them before the Claims Administrator or the Plan Administrator. The claimant will be copied on all written communications with the representative, unless the claimant directs otherwise in writing.

Submitting a Claim for Benefits

All Claims Other than Prescription Drug, Mental Health, Substance Abuse and Chemical Dependency Claims. If you receive care from a provider who is in a provider network, the provider will submit the charges directly to the Claims Administrator for payment. You do not need to submit a separate claim form to the Claims Administrator. The Claims Administrator will pay benefits directly to the network provider. You should not pay the provider until the Claims Administrator has paid the provider and you receive the Explanation of Benefits ("EOB"). The EOB will contain the amount of the discount as well as the amount you owe the provider after Medical Program payments have been made.

If you do not use a network provider, each claim you submit during a calendar year for yourself and for each dependent must be accompanied by a claim form completed by you. Claim forms are available on the Claims Administrator's website or by calling the Claims Administrator. For non-network providers including remote area providers your medical claims (other than claims relating to mental health, substance abuse or chemical dependency) should be sent to the Claims Administrator at the address provided in the Contact Information Sheet.

You may also call the Claims Administrator at the telephone number listed in the Appendices.

Once a claim form has been filed on behalf of an individual, subsequent claims filed during the rest of the year for that person do not have to be accompanied by a claim form; you may submit just the itemized bills. Each bill must contain all information required by the Claims Administrator.

The Claims Administrator may periodically request information to determine the medical necessity for submitted claims. Payment for the expenses for which information is requested will be withheld until the information is received. If the required information is not provided within 90 days of the date it is requested, no payment will be made for the charges for which the information is requested and the claim will be considered denied.

If your coverage under this Medical Program is secondary to coverage that you have under another plan, you should submit the "Explanation of Benefits" statement from the primary plan along with the itemized bill or receipt(s).

Mental Health, Substance Abuse or Chemical Dependency Claims. The Claims Administrators for claims for mental health, substance abuse and chemical dependency services under the coverage options are provided in the Contact Information Sheet.

Claim forms are available at the website provided in the Appendices or by calling the Claims Administrator. Mental health, substance abuse and chemical dependency claims will be processed and paid by the Claims Administrator.

Types of Claims

The following factors vary depending on the urgency of a claim for Medical Program benefits and whether it is filed before or after you or your dependent receives treatment:

- how a claim for benefits is made;
- the time period within which a benefit claim must be decided (and whether an extension of that time period is permitted);
- the form in which the decision is communicated, and the required content of the decision; and
- the procedure (including time frames) to be followed if the Claims Administrator needs additional information from the claimant to make a decision on the claim.

The timeframe for deciding a claim is determined based on whether it is filed:
- before receiving medical services (a "Pre Service Claim"),
- during a period in which you or your dependent receives continuous or intermittent related medical services (a "Concurrent Care Claim"), or
- after receiving medical services (a "Post Service Claim").

The time and procedure for deciding a Pre Service Claim varies depending on whether the claim is "urgent."

Time Frames and Procedures for Initial Claim Decision

The Claims Administrator will process claims within the following timeframes, although the claimant may voluntarily extend these timeframes.

Urgent Pre-Service Claims. A decision will be made within 36 hours for EPO claims and 72 hours for PPO claims following receipt of a claim request if the claim is complete. If the Claims Administrator determines that the claim is incomplete, the claimant will have 48 hours to provide information requested by the Claims Administrator. Notice of the decision will be by telephone, e-mail or facsimile. Written notice will be provided within three days following an oral notification.

Non-Urgent Pre-Service Claims. A decision will be made within 15 calendar days following receipt of a completed claim request, but the Claims Administrator may have a 15-day extension if written notice is given to the claimant within the original 15-day period. Written notice of the decision will be provided.

Post-Service Claims. Claims will be processed within 30 calendar days, but the Claims Administrator may have a 15-day extension if written notice is given to the claimant within the original 30-day period.

Concurrent Care Decisions. Notice of the adverse decision will be given to the claimant sufficiently in advance to allow the claimant to obtain a decision on review before the benefit is reduced or terminated. A request to extend approved concurrent care will be considered a pre-service claim. If the claim is urgent, the urgent pre-service claim procedures will apply, except that notice of any adverse decision will be given to the claimant within 24 hours of the Claims Administrator's receipt of a request if the claim is made at least 24 hours before the expiration of the previously approved course of treatment. If the claim is not urgent, the non-urgent pre-service claim procedures will apply.

Improper or Incomplete Claim

The Claims Administrator may notify you that your claim is improper or incomplete. The time from the date of the notice requesting further information until such information is received does not count toward the time period the Claims Administrator is allowed to notify the claimant of its decision. The claimant has 45 days after receiving the notice to provide additional information or complete the claim for non-urgent, pre-service, and post-service claims.

Exam

Before paying a claim, the Claims Administrator or the Plan Administrator may require an examination by an independent physician of any person whose non-occupational illness or Injury is the basis of a claim or his or her medical records.

Adverse Claim Determination

If the decision is adverse, you will be provided a notice that includes:
- the reason(s) for the adverse decision;

- reference to the plan provision(s) or guidelines, protocol or similar criteria on which the adverse decision is based;
- a description of any additional information necessary for the claimant to complete the claim and an explanation as to why such information is necessary; and
- appropriate information as to the steps the claimant can take to submit the claim for review (appeal).

Access to Relevant Documents

The Claims Administrator will provide to the claimant on request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon;
- records of any independent reviews conducted by the Medical Program;
- medical judgments, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate; and
- expert advice on consultation obtained by the Medical Program in connection with your denied claim, whether or not the advice was relied upon.

Appeal Procedures

You are entitled to full and fair review of initial claim decisions and appeal review decisions made under the Plan. If you have any questions regarding the claims and appeal procedures, please contact the applicable Claims Administrator.

If an adverse decision is made, the claimant may request that the decision be reviewed. Appeals should be sent to the applicable Claims Administrator shown in the Appendices.

The claimant may submit, with the appeal, written comments, documents, records and other information related to the claim for benefits. The appeal will be reviewed and decided by the Claims Administrator or its designee. A request for review must be made within 180 days of the date the claimant receives notice of the adverse decision. Please note that if your health care provider is appealing payment under the health care provider's network provider contract with the Claims Administrator, the 180-day period for you to appeal is still running. The period of time the Claims Administrator has to make its decision, and whether an extension is available, depends on the type of claim at the time it is appealed, and is described below. A claimant may voluntarily agree to provide the Claims Administrator with additional time to decide an appeal.

Urgent Pre-Service Appeals. An appeal may be made orally, including by telephone, or in writing. A decision will be made within the time frames specified – no extension is available. Notice will be provided by telephone, e-mail or facsimile; written notice will be made within three days of an oral notification.

Non-Urgent Pre-Service Appeals. A decision will be made within a reasonable period of time appropriate to the medical circumstances but no later than within the time frames specified after the Claims Administrator receives the claimant's request for review – no extension is available.

Post-Service Appeals. A decision will be made within a reasonable period of time if the claim is complete, but no later than 30 days after the Claims Administrator receives the claimant's complete request for review – no extension is available.

Concurrent Care Decisions. A decision will be made sufficiently in advance of when the treatment ends or is reduced to allow the claimant to obtain a decision on review before the benefit is reduced or terminated. A request to extend approved concurrent care will be considered a pre-service appeal. If the appeal is urgent, the urgent pre-service appeal procedures will apply, except that notice of any adverse decision will be given to the claimant within 24 hours of the Claims Administrator's receipt of a request if the appeal is made at least 24 hours before the expiration of the previously approved course of treatment. If the appeal is not urgent, the non-urgent pre-service appeal procedures will apply.

Submission and Consideration of Comments. The claimant has the opportunity to submit written comments, documents, records, or other information in support of the appeal. The appeal review will take into account the information whether or not submitted or considered in the initial decision. No deference will be given to the initial decision.

Independent Review. The review will be conducted by a named fiduciary for the Plan. The reviewer will not be the same person who made the initial decision on the claim or someone who works for that person. The reviewer will make an independent decision on the claim. The information in the administrative record shall be reviewed. Additional information submitted shall be considered. The decision will be based upon that information plus the terms of the Plan and past interpretations of the same and similar Plan provisions. The reviewer may rely upon protocols, guidelines, or other criterion.

Consultation with a Medical Expert. In the case of a claim denied on the grounds of a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience in the field of medicine which is the basis for the medical judgment. The health care professional who is consulted on appeal will not be the person, if any, who was consulted during the initial decision, or a person who works for him or her.

Disclosure of Medical Expert. If the advice of a medical expert was obtained by the Claims Administrator in connection with the claim denial, the name and credentials of the expert will be provided to the claimant upon request whether or not the Claims Administrator relied on the advice in making the adverse decision.

Notice of Decision on Appeal

Written (or electronic) notification of the decision on appeal will be provided to the claimant whether the initial decision is upheld or reversed.

If the adverse decision is reversed, the Claims Administrator will provide written notice of that fact. If the adverse decision is upheld in whole or in part, the Claims Administrator will provide written notice to the claimant that includes:

- the reason(s) for the adverse decision;
- reference to the plan provision(s) or guidelines, protocol or similar criteria on which the adverse decision is based;
- if the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or is experimental), either an explanation of the scientific or clinical judgment for the decision, or a statement that such an explanation will be provided free of charge upon request;
- a description of any information necessary for the claimant to complete the appeal and an explanation as to why such information is necessary; and
- a statement of your right to file a second level appeal or bring a civil action under ERISA, as the case may be.

Improper or Incomplete Claims or Appeals

Please note, if the Claims Administrator notifies you that further information is required in order to decide an appeal, you will have 45 days to provide such information to the Claims Administrator for non-urgent claims. The maximum period for deciding your appeal (based on the type of claim) will not continue to run until you either (i) provide the requested information, or (ii) fail to do so within 45 days of the Claims Administrator's request.

Second Level of Appeal

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with the Claims Administrator. You will be notified of the decision no later than the applicable deadline. If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Claims Administrator within 60 days of receipt of the level one appeal decision. The Claims Administrator will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

External Review

You may request an external review by an independent third party within four months of the date you receive an adverse decision notice if you are not satisfied with the Claims Administrator's decision on appeal. Denials based on eligibility are not eligible for external review.

The Claims Administrator for mental health, substance abuse and chemical dependency treatment claims may be contacted at the address shown in the Contact Information Sheet:

The Claims Administrator will determine whether the claim is eligible for review under the external review process. The determination will be based on whether:

- You are or were covered under a coverage option at the time the claim was made or incurred;
- the denial relates to your failure to meet the eligibility requirements of the coverage option;
- the denial relates to either an adverse benefit determination that involves medical judgment or a rescission of coverage;
- you exhausted the internal claims and appeal procedures of the coverage option (unless you were not required to exhaust the internal appeals process); and
- you have provided all the information required to process an external review.

The Claims Administrator will provide written notification to you or your authorized representative of whether the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Claims Administrator will notify you or your authorized representative of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it.

If the request is eligible for the external review process, the Claims Administrator will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying you, in writing, that the request for external review has been accepted. The notice should include a statement that you may submit in writing, within ten business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Claims Administrator. The Claims Administrator may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the external review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the plan or issuer, you or your treating provider;
- the terms of the coverage option;
- appropriate practice guidelines;
- any applicable clinical review criteria developed and used by the coverage option; and
- the opinion of the IRO's clinical reviewer.

The IRO must provide written notice to you and the coverage option of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

- a general description of the reason for the external review, including information sufficient to identify the claim (including date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the review and the date of the IRO's decision;

- references to the evidence or documentation considered by the IRO in reaching its decision;
- a discussion of the principal reason(s) for the IRO's decision;
- a statement that the determination is binding and that judicial review may be available; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Expedited External Review

You may request an expedited external review at the time you receive:

- an adverse benefit determination of a claim or appeal, if the adverse benefit determination (i) involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or (ii) would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal determination, if you have a medical condition where the timeframe for completion of a standard external review would (i) seriously jeopardize your life or health or (ii) jeopardize your ability to regain maximum function, or if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Claims Administrator must immediately send you a notice of its eligibility determination.

Upon a determination that a request is eligible for expedited external review following preliminary review, the Claims Administrator will assign an IRO. The IRO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Claims Administrator.

Subrogation and Reimbursement

Except as otherwise provided in a controlling collective bargaining agreement, these subrogation and reimbursement provisions apply to all coverage options. Sometimes, you or your dependent may have a claim for a non-occupational Illness or injury, such as a car accident, that someone else is responsible for paying. The portion of the expense that the other party (which may be an individual, a company or an insurer) is responsible for paying is not considered a Covered Expense under the Medical Program. Also, the Medical Program does not provide benefits if there is other coverage under any automobile policy, homeowner's policy, workers' compensation, or similar insurance coverage. However, the Plan may advance you payment of the expense as a benefit in exchange for you and your dependents granting the Plan the right of subrogation, reimbursement and recovery. By enrolling in a Medical Program coverage Option, as well as by applying for payment of Covered Expenses, you and your dependents are subject to and agree with the following rules:

- **Reimbursement Agreement.** If you or your dependent incur Covered Expenses that are excluded because they are or may be the responsibility of a third party, you or your dependent must sign the coverage option's reimbursement agreement in order to receive benefits. The agreement acknowledges your or your dependent's obligation to reimburse the Plan from the first dollars recovered from any source. If expenses are incurred by a minor dependent, the Plan Administrator may require that the minor's parent or legal guardian execute the reimbursement agreement and agree to be bound by it. The Plan Administrator may, in its discretion, withhold benefit payments that might otherwise be advanced, and/or prosecute an action at law or in equity in its own name or in your name, in order to enforce, secure, or protect the Plan's rights. If you or your dependent do not execute the agreement, the Plan is not obligated to provide any benefit payments.

- **Right of Reimbursement.** Whether or not you or your dependent execute a reimbursement agreement, in the event that the Plan provides benefits under a Medical Program coverage Option,

and you or your dependent recover a payment, either by settlement, judgment, no-fault automobile insurance statute or otherwise, from any third party, then you or your dependent must immediately reimburse the Plan for the full amount of any and all benefits paid in connection with the non-occupational illness or injury (reduced by any average discount percentage applicable to prescription drug benefits) up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of Injuries. This right provides the Plan with priority over any funds paid by a third party or insurer, without regard to whether you or your covered dependent has been made whole. If the recovery is for damages other than for Covered Expenses under the coverage option (such as pain and suffering) you or your dependent will still be required to reimburse the Plan first. The Plan has a lien on any such recovery in the amount of the benefits paid by the Plan.

- **Right of Subrogation**. Whether or not you or your dependent execute a reimbursement agreement, if the Plan pays for a Covered Expense for which another party was responsible, the Plan is subrogated to all of your or your dependent's rights of recovery against any party to the extent of the benefits provided. This means that the Plan shall also have a lien on any recovery from such third party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The Plan's right of subrogation shall apply to the first dollar of any recovery obtained from the third party, even if the recovery obtained is less than the amount needed to make you whole. If the Plan is precluded from exercising its right of subrogation or chooses not to exercise that right, the Plan has discretion whether or not to pay benefits.

The following are examples of when the subrogation and reimbursement rights described above apply:

- Payments made directly by a third party or any insurance company on behalf of the third party or any other payments on behalf of the third party;
- Any payments or settlements or judgment or arbitration awards paid by any insurance company under any uninsured or underinsured motorist coverage;
- Any other payments from any source designed or intended to compensate you or your dependent for injuries sustained as the result of negligence or alleged negligence of a third party;
- Any worker's compensation award or settlement;
- Any recovery made pursuant to no-fault insurance; and
- Any medical payments made as the result of such coverage in any automobile or homeowners insurance policy.

- **Duty to Cooperate**. You and your dependent are required to cooperate fully with the Plan in connection with the exercise of its rights, to provide such information, assistance and documents as the Plan may require to help enforce its rights, and to not do anything to hurt such rights. This duty includes, but is not limited to, the following:

  - You or your dependent must notify the Plan as soon as possible that the Plan may have a right to obtain restitution, reimbursement or other available remedy of any and all benefits paid by the Plan on your behalf in connection with an accident, illness or injury that is the result of another party. You may notify the Plan under a coverage option by contacting the Plan Administrator's designated subrogation administrator listed on the Contact Information Sheet.

    You may notify the Plan by contacting the Claims Administrator directly at the address contained therein. This also means that, if you or your dependent goes to the hospital because of an accident, illness or injury that is the result of another party, you or your dependent must inform the hospital staff that the sickness or injuries are the result of the actions for which another person may be liable.

    If you retain legal counsel, your legal counsel must also contact the Plan Administrator's designated subrogation administrator listed on the Contact Information Sheet.

- You or your dependent must notify the Plan before filing any suit and may not settle any claim against a third party without giving notice to and obtaining the consent of the Plan Administrator. If you or your dependent notify the Plan before suit or settlement, the Plan may retain your or your dependent's attorney to represent the Plan. If the Plan hires your or your dependent's attorney, the Plan will agree with the attorney on the amount of attorneys' fees and expenses that the Plan will pay. The Plan is not bound by the amount or percent of your or your dependent's attorneys' fees, nor may the amount or percent of such fees be subtracted from the amount that is required to be repaid to the Plan without the Plan's consent. If you do not timely notify the Plan of suit or settlement, or do not cooperate with the Plan, or oppose the Plan in enforcing the Plan's subrogation or reimbursement rights, you must pay the Plan's attorneys' fees and costs incurred because of your actions or failure to act, in addition to any other rights or remedies that the Plan may have.

- **Equitable Lien and Other Equitable Remedies**. The Plan will have an equitable lien against any rights you or your dependent may have to recover the full amount of benefits paid by the Plan for Covered Expenses from any party, including an insurer or another group health program. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid benefits for Covered Expenses under a coverage option prior to a determination that the Covered Expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the Company will be deemed to mean that such a determination has been made.

  This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, you, your dependent, your or your dependent's attorney, and/or a trust) as a result of an exercise of your or your dependent's right of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the Company's sole discretion, the Plan may reduce any future payments for Covered Expenses otherwise available to you or your dependent under a coverage option by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien.

  This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decisions entitled *Great-West Life & Annuity Insurance Co. v. Knudson*, 122 S.Ct. 708 (2002), and *Sereboff v. Mid Atlantic Medical Services*, 126 S. Ct. 1869 (2006), *U.S. Airways v. McCutcheon*, 569 U.S. ___ (2013), and their progeny.

- **Right of Recovery or Offset**. The Plan has the right to withhold the payment of benefits under a coverage option if you or your dependent do not comply with these requirements, and has the right to recover any benefits paid to you, your dependent or your or your dependent's health care provider in error. The Plan may stop paying benefits under a reimbursement agreement if the Plan Administrator determines that you have failed or are failing to fulfill your duty to cooperate. These rights are in addition to any other rights and remedies that the Plan may have. In connection with this right of recovery or offset, please consider the following:

  - You or your adult dependents may not assign any rights to recover the amount of Covered Expenses from any party to any of your or your dependent's minor child or children without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to settlements or recoveries of decedents, minors and incompetent or disabled persons.
  - You may not make any settlement that reduces or excludes, or attempts to reduce or exclude, the benefits provided under a coverage option.
  - The Plan's rights described above cannot be defeated or reduced by the application of any "made-whole doctrine" or similar doctrine or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- You or your dependents may not incur expenses on behalf of the Plan in pursuit of its rights. Specifically, neither court costs nor attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right cannot be defeated by any so-called "fund doctrine," "common fund doctrine," or similar doctrine.
- The Plan has the right to recover the full amount of benefits provided without regard to any claim of fault on the part of you or your dependent, whether under comparative negligence or otherwise.
- The benefits under the Plan are secondary to any coverage under no-fault or similar insurance.
- If you do not honor your obligations, the Plan will be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs and other expenses.

The above rules shall apply unless the applicable subrogation and reimbursement provisions under any coverage option are, in the Plan Administrator's sole discretion, more favorable to the Plan and/or the Company, in which case such provisions shall instead apply to such coverage option.

Limitation on Bringing Legal Action

You (or your beneficiary) must exhaust your appeal rights under the Medical Program, including the external review process described above, before bringing any legal action with respect to a claim for benefits under the Medical Program. In addition, any such action must be brought within three years from the date on which you submitted your claim or such claim was required to be submitted, whichever is earlier.

Assignment of Benefits and Other Rights

Except as may be otherwise permitted by the Plan Administrator, you may not assign, sell or otherwise transfer your right to any payments or other benefits, or your right to request documents, under the Medical Program. If you receive services from a hospital or physician that participates in a coverage network, the hospital or physician will submit the bills for you and benefits will automatically be paid to the provider of services. If you receive care from a provider who is not in a coverage network, you may be required by the provider to pay the bill in full and then request reimbursement from the Medical Program.

Dental Program

Section 1. Introduction

The Dental Program offers multiple coverage options, including one or more preferred provider organization ("PPO") options. **The key provisions of each coverage option available to you are set forth in the Schedule of Benefits attached as an Addendum to this SPD.** In addition, one or more dental health maintenance organization ("DHMO") options may be available to you. Additional detailed information on each coverage option, including each DHMO option, can be found on the Plan Website.

Section 2. Eligibility and Coverage

Initial Eligibility

As a regular full-time or part-time employee, you and your eligible dependents are eligible to participate in the Dental Program when you satisfy the service requirements described in the "Participation" section in the General Information Chapter.

Dependent Eligibility

Your dependent is eligible for coverage on the same date you become eligible or, if later, on the day he or she first becomes your dependent. In order for your dependent to receive coverage, you must enroll him or her within 45 days of the date he or she first becomes eligible. Coverage will be retroactive to the date of eligibility (marriage, domestic partnership, birth or adoption). Otherwise, you may not enroll your dependent until the next Annual Enrollment Period.

Section 3. DHMO Coverage Options

As noted above, one or more DHMO options may be available to you. Depending on where you live, you may be eligible to elect a DHMO option in lieu of other coverage options. Additional rules and a description of Covered Expenses and exclusions are provided by the applicable HMO in a separate booklet. In all cases, your rights and benefits and those of your dependents are governed by the terms and conditions of the Plan and the applicable DHMO documents. For additional information regarding DHMO coverage options that may be available to you, please see the Plan Website.

If you enroll in a DHMO option, the DHMO will send you an identification card for you and your covered dependents. This card must be presented to the hospital, medical provider and/or pharmacy when you or a dependent receives medical treatment.

Section 4. Paying for Services

Participant Contributions

The required contribution for each month of coverage under the Dental Program is based on a four-tier structure of coverage:

- 1 Adult (*Employee or Surviving Spouse or Surviving Domestic Partner*);
- 1 Adult and Dependent Child(ren) (*Employee plus Dependent Child(ren) or Surviving Spouse or Surviving Domestic Partner plus Dependent Child(ren)*);
- 2 Adults (*Employee plus Spouse or Domestic Partner*); and
- Family (*Employee plus Spouse and Dependent Child(ren) or Employee plus Domestic Partner and Dependent Child(ren)*).

Your monthly contribution will be communicated to you in connection with initial or annual open enrollment. The monthly contribution amount varies by employee group and coverage option. In addition, you may contact the UABC to obtain your monthly contribution information.

Section 5. Covered Expenses and Exclusions

Generally

Each coverage option has a specific list of covered expenses and exclusions, including for emergency services. The term "covered expenses" means the dental expenses incurred by an employee or dependent that are recognized as payable under the applicable coverage option, subject to certain exclusions. Please see the Schedule of Benefits attached as an Addendum to this SPD.

Dentally Necessary

The Plan Administrator or its delegate makes all determinations whether an expense is dentally necessary under the coverage option in accordance with the standards and procedures applicable to such coverage option.

Section 6. Maintenance of Benefits and Coordination of Benefits

If both you and a dependent work, it is possible for you and your family to be covered under more than one group health care plan. The Dental Program contains maintenance of benefits provisions to coordinate coverage under the plans. This means that the Dental Program works with other group plans to provide you with benefits up to the benefit amount provided by the higher plan. For example, if this Plan is the secondary plan and the primary plan covers a claim at a level which is less than the coverage under the Plan, the Plan will only pay the portion of the claim necessary to bring the total coverage up to the level provided under the Plan. Please consult the Plan's governing documents for additional information.

Section 7. Claims and Appeals Procedures

This section describes the procedures for submitting and, if necessary, appealing a claim for benefits under a coverage option.

Claims Relating to Eligibility to Participate or Enrollment

If you inquire as to your eligibility for Dental Program coverage independent of a claim for benefits, your inquiry will be treated as an eligibility claim and will be decided in accordance with separate claims and appeals procedures described in the section entitled "Claims Relating to Eligibility to Participate or Enrollment" in the General Information Chapter.

Please note, a claim for dental services or treatment may be denied because you or your dependent did not satisfy the Plan's eligibility criteria. Such a claim (and subsequent appeal, if any) will be decided in accordance with the procedures described below for claims relating to benefits.

Claims Relating to Dental Services, Treatments, and Other Benefits

The applicable Claims Administrator makes determinations on behalf of the Plan as to whether or not a claim for dental services, treatments, etc. is payable under the terms of the Plan.

A "claim" is a request for a Plan benefit. A "claimant" is the individual who is making a request for Plan benefits. A "representative" can make a claim or appeal a claim on the claimant's behalf. The Plan will recognize a health care professional with knowledge of the claimant's dental condition as the claimant's representative for purposes of the initial submission of a claim, unless the claimant provides written direction otherwise. A parent or guardian may act on a dependent child's behalf. In all other situations, the claimant must notify the Plan in writing of a representative. The claimant will be copied on all written communications with the representative, unless the claimant directs otherwise in writing.

Types of Claims

The following factors vary depending on the urgency of a claim for Dental Program benefits and whether it is filed before or after you or your dependent receives treatment:

- how a claim for benefits is made;
- the time period within which a benefit claim must be decided (and whether an extension of that time period is permitted);
- the form in which the decision is communicated, and the required content of the decision; and
- the procedure (including time frames) to be followed if the Claims Administrator needs additional information from the claimant to make a decision on the claim.

The timeframe for deciding a claim is determined based on whether it is filed:

- before receiving dental services (a "Pre Service Claim"),
- during a period in which you or your dependent receives continuous or intermittent related dental services (a "Concurrent Care Claim"), or
- after receiving dental services (a "Post Service Claim").

The time and procedure for deciding a Pre Service Claim varies depending on whether the claim is "urgent."

Time Frames and Procedures for Initial Claim Decision

The Claims Administrator will process claims within the following timeframes, although the claimant may voluntarily extend these timeframes.

Urgent Pre-Service Claims. A decision will be made within 36 hours for EPO claims and 72 hours for PPO claims following receipt of a claim request if the claim is complete. If the Claims Administrator determines that the claim is incomplete, the claimant will have 48 hours to provide information requested by the Claims Administrator. Notice of the decision will be by telephone, e-mail or facsimile. Written notice will be provided within three days following an oral notification.

Non-Urgent Pre-Service Claims. A decision will be made within 15 calendar days following receipt of a completed claim request, but the Claims Administrator may have a 15-day extension if written notice is given to the claimant within the original 15-day period. Written notice of the decision will be provided.

Post-Service Claims. Claims will be processed within 30 calendar days, but the Claims Administrator may have a 15-day extension if written notice is given to the claimant within the original 30-day period.

Concurrent Care Decisions. Notice of the adverse decision will be given to the claimant sufficiently in advance to allow the claimant to obtain a decision on review before the benefit is reduced or terminated. A request to extend approved concurrent care will be considered a pre-service claim. If the claim is urgent, the urgent pre-service claim procedures will apply, except that notice of any adverse decision will be given to the claimant within 24 hours of the Claims Administrator's receipt of a request if the claim is made at least 24 hours before the expiration of the previously approved course of treatment. If the claim is not urgent, the non-urgent pre-service claim procedures will apply.

Improper or Incomplete Claim

The Claims Administrator may notify you that your claim is improper or incomplete. The time from the date of the notice requesting further information until such information is received does not count toward the time period the Claims Administrator is allowed to notify the claimant of its decision. The claimant has 45 days after receiving the notice to provide additional information or complete the claim for non-urgent, pre-service, and post-service claims.

Adverse Claim Determination

If the decision is adverse, you will be provided a notice that includes:

- the reason(s) for the adverse decision;
- reference to the plan provision(s) or guidelines, protocol or similar criteria on which the adverse decision is based;
- a description of any additional information necessary for the claimant to complete the claim and an explanation as to why such information is necessary; and
- appropriate information as to the steps the claimant can take to submit the claim for review (appeal).

Access to Relevant Documents

The Claims Administrator will provide to the claimant on request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon;
- records of any independent reviews conducted by the Dental Program;
- medical judgments, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate; and
- expert advice on consultation obtained by the Dental Program in connection with your denied claim, whether or not the advice was relied upon.

Appeal Procedures

You are entitled to full and fair review of initial claim decisions and appeal review decisions made under the Plan. If you have any questions regarding the claims and appeal procedures, please contact the applicable Claims Administrator.

If an adverse decision is made, the claimant may request that the decision be reviewed. Appeals should be sent to the applicable Claims Administrator shown in the Appendices.

The claimant may submit, with the appeal, written comments, documents, records and other information related to the claim for benefits. The appeal will be reviewed and decided by the Claims Administrator or its designee. A request for review must be made within 180 days of the date the claimant receives notice of the adverse decision. Please note that if your dental care provider is appealing payment under the dental care provider's network provider contract with the Claims Administrator, the 180-day period for you to appeal is still running. The period of time the Claims Administrator has to make its decision, and whether an extension is available, depends on the type of claim at the time it is appealed, and is described below. A claimant may voluntarily agree to provide the Claims Administrator with additional time to decide an appeal.

Urgent Pre-Service Appeal. An appeal may be made orally or in writing. A decision will be made within 72 hours – no extension is available. Notice will be provided by telephone, e-mail or facsimile; written notice will be made within three days of an oral notification.

Non-Urgent Pre-Service Appeal. A decision will be made within a reasonable period of time appropriate to the dental circumstances but no later than 30 calendar days after the Plan Administrator receives the claimant's request for review – no extension is available.

Post-Service Appeal. A decision will be made within a reasonable period of time but no later than 60 days after the Plan Administrator receives the claimant's request for review – no extension is available.

Concurrent Care Decisions. A decision will be made before the treatment ends or is reduced.

Submission and Consideration of Comments. The claimant has the opportunity to submit written comments, documents, records, or other information in support of the appeal. The appeal review will take into account the information whether or not submitted or considered in the initial decision. No deference will be given to the initial decision.

Independent Review. The review will be conducted by a named fiduciary for the Plan. The reviewer will not be the same person who made the initial decision on the claim or someone who works for that person. The reviewer will make an independent decision on the claim. The information in the administrative record shall be reviewed. Additional information submitted shall be considered. The decision will be based upon that information plus the terms of the Plan and past interpretations of the same and similar Plan provisions. The reviewer may rely upon protocols, guidelines, or other criterion.

Consultation with a Dental Expert. In the case of a claim denied on the grounds of a dental judgment, a health care professional with appropriate training and experience in the field of medicine which is the basis for the dental judgment will be consulted. The health care professional who is consulted on appeal will not be the person, if any, who was consulted during the initial decision or a person who works for him or her.

Disclosure of Dental Expert. If the advice of a dental expert was obtained by the Plan Administrator in connection with the claim denial, the name and credentials of the expert will be provided to the claimant upon request, whether or not the Plan Administrator relied on the advice in making the adverse decision.

Notice of Decision on Appeal

Written (or electronic) notification of the decision on appeal will be provided to the claimant whether the initial decision is upheld or reversed.

If the adverse decision is reversed, the Claims Administrator will provide written notice of that fact. If the adverse decision is upheld in whole or in part, the Claims Administrator will provide written notice to the claimant that includes:

- the reason(s) for the adverse decision;
- reference to the plan provision(s) or guidelines, protocol or similar criteria on which the adverse decision is based;
- if the decision is based on a dental limit (for example, a decision that the proposed service is not dentally necessary or is experimental), either an explanation of the scientific or clinical judgment for the decision, or a statement that such an explanation will be provided free of charge upon request;
- a description of any information necessary for the claimant to complete the appeal and an explanation as to why such information is necessary; and
- a statement of your right to file a second level appeal or bring a civil action under ERISA, as the case may be.

Please note, if the Claims Administrator notifies you that further information is required in order to decide an appeal, you will have 45 days to provide such information to the Claims Administrator for non-urgent claims. The maximum period for deciding your appeal (based on the type of claim) will not continue to run until you either (i) provide the requested information, or (ii) fail to do so within 45 days of the Claims Administrator's request.

Limitation on Bringing Legal Action

You (or your beneficiary) must exhaust your appeal rights under the Dental Program before bringing any legal action with respect to a claim for benefits under the Dental Program. In addition, any such action must be brought within 12 months from the date on which you submitted your claim or such claim was required to be submitted, whichever is earlier.

Assignment of Benefits and Other Rights

Except as may be otherwise permitted by the Plan Administrator, you may not assign, sell or otherwise transfer your right to any payments or other benefits, or your right to request documents, under the Dental Program. If you have received services and have not yet paid the dentist and wish payment to be made directly to the dentist, you must fill out the assignment of benefits statement on the claim form. Not all providers accept assignment of benefits, particularly providers outside the United States. In that event,

you may be required by the provider to pay the bill in full. The Claims Administrator, at the direction of the Plan Administrator, has the right to make payment directly to any provider.

Vision Program

Section 1. Introduction

The Vision Program offers vision benefits under one or more coverage options (collectively, the "Vision Options"). **Detailed information on the Vision Options can be found on the Plan Website.**

Section 2. Eligibility and Coverage

Initial Eligibility

As a regular full-time or part-time employee, you and your eligible dependents are eligible to participate in the Vision Program when you satisfy the service requirements described in the "Participation" section in the General Information Chapter.

Dependent Eligibility

Your dependent is eligible for coverage on the same date you become eligible or, if later, on the day he or she first becomes your dependent. In order for your dependent to receive coverage, you must enroll him or her within 45 days of the date he or she first becomes eligible. Coverage will be retroactive to the date of eligibility (marriage, domestic partnership, birth or adoption). Otherwise, you may not enroll your dependent until the next Annual Enrollment Period.

Section 3. Paying for Services

Participant Contributions

The required contribution for each month of coverage under the Vision Program is based on a four-tier structure of coverage:

- 1 Adult (*Employee or Surviving Spouse or Surviving Domestic Partner*);
- 1 Adult and Dependent Child(ren) (*Employee plus Dependent Child(ren) or Surviving Spouse or Surviving Domestic Partner plus Dependent Child(ren)*);
- 2 Adults (*Employee plus Spouse or Domestic Partner*); and
- Family (*Employee plus Spouse and Dependent Child(ren) or Employee plus Domestic Partner and Dependent Child(ren)*).

Your monthly contribution will be communicated to you in connection with initial or annual open enrollment. The monthly contribution amount varies by employee group and coverage option. In addition, you may contact the UABC to obtain your monthly contribution information.

Section 4. Covered Expenses and Exclusions

Each coverage option has a specific list of covered expenses and exclusions. The term “covered expenses” means the vision expenses incurred by an employee or dependent that are recognized as payable under the applicable coverage option, subject to certain exclusions.

Section 5. Claims and Appeals Procedures

This section describes the procedures for submitting and, if necessary, appealing a claim for benefits under a coverage option.

Claims Relating to Eligibility to Participate or Enrollment

If you inquire as to your eligibility for Vision Program coverage independent of a claim for benefits, your inquiry will be treated as an eligibility claim and will be decided in accordance with separate claims and appeals procedures described in the section entitled "Claims Relating to Eligibility to Participate or Enrollment" in the General Information Chapter.

Please note, a claim for vision benefits may be denied because you or your dependent did not satisfy the Plan's eligibility criteria. Such a claim (and subsequent appeal, if any) will be decided in accordance with the procedures described below for claims relating to benefits.

Claims and Appeals Procedures Relating to Vision Benefits

The applicable Claims Administrator makes determinations on behalf of the Plan as to whether or not a claim for vision benefits is payable under the terms of the Plan. The claims and appeals procedures for vision benefits are the same as those described in the section entitled "Claims and Appeals Procedures" in the Medical Program Chapter.

Improper or Incomplete Claim

The Claims Administrator may notify you that your claim is improper or incomplete. The time from the date of the notice requesting further information until such information is received does not count toward the time period the Claims Administrator is allowed to notify the claimant of its decision. The claimant has 45 days after receiving the notice to provide additional information or complete the claim for non-urgent, pre-service, and post-service claims.

Limitation on Bringing Legal Action

You (or your beneficiary) must exhaust your appeal rights under the Vision Program before bringing any legal action with respect to a claim for benefits under the Vision Program. In addition, any such action must be brought within 12 months from the date on which you submitted your claim or such claim was required to be submitted, whichever is earlier.

Assignment of Benefits and Other Rights

Except as may be otherwise permitted by the Plan Administrator, you may not assign, sell or otherwise transfer your right to any payments or other benefits, or your right to request documents, under the Vision Program.

If you have received services and have not yet paid the dentist and wish payment to be made directly to the dentist, you must fill out the assignment of benefits statement on the claim form. Not all providers accept assignment of benefits, particularly providers outside the United States. In that event, you may be required by the provider to pay the bill in full. The Claims Administrator, at the direction of the Plan Administrator, has the right to make payment directly to any provider.

Flexible Spending Program

Section 1. Introduction

The Flexible Spending Program provides you with a tax-effective way to pay for health care expenses that are not covered under the Medical, Dental or Vision Programs, and to pay for dependent care expenses.

Overview of How the Flexible Spending Program Works

The Flexible Spending Program offers you the opportunity to contribute a portion of your salary to the following flexible spending accounts ("FSAs"):

- a "general-purpose" health care FSA (which can be used to reimburse you for eligible health care expenses, such as medical, dental, and vision expenses);
- a "limited-purpose" health care FSA (which can only be used to reimburse you for eligible health care expenses for certain unreimbursed dental and vision services); and
- a dependent care FSA (which can be used to reimburse you for qualifying child care and other dependent care expenses).

If you decide to contribute to an FSA, your contributions will automatically be made on a pre-tax basis from your paycheck and deposited in your FSA. **Please note that, if you wish to enroll in a Health Care FSA, you may enroll in either the general-purpose FSA or limited-purpose FSA, but not both**.

You will be reimbursed for eligible health care and dependent care expenses that you have incurred upon your submission of a claim for reimbursement, along with the required documentation, as described below.

If you have any questions about the FSAs, need claim forms, or wish to access information regarding your FSA elections, or check the status of a claim for reimbursement from an FSA, you may contact the Claims Administrator at the phone number or website shown on the Contact Information Sheet.

Section 2. Eligibility and Coverage

Employee Coverage

If you are a regular full-time or part-time employee of the Company paid on the U.S. payroll, you are eligible to participate in the Flexible Spending Program. However, the Flexible Spending Program is not available to employees in Puerto Rico due to differences in its tax laws. Also, if you are an international flight attendant, we urge you to consult with your tax advisor before electing to enroll in the Flexible Spending Program.

Although your dependents are not eligible to enroll in the Flexible Spending Program (only employees may enroll), you may submit eligible expenses you have incurred for care provided to your eligible dependents for reimbursement from your FSAs.

Section 3. FSA Contributions and Reimbursements

Determining Your Voluntary FSA Contributions

After you elect to contribute to an FSA, your total annual contribution for the year will be divided into payroll deductions among the remaining payroll periods for the calendar year. If you elect an FSA benefit during the Annual Enrollment Period, this means that you will have regular payroll deductions during the

following calendar year (assuming that you are in pay status for the entire year and do not terminate your FSA participation during the year).

The maximum annual amount you may contribute to each FSA may be found in our FAQ document or by contacting the Benefits Center.

Reimbursement

The entire amount of your annual contribution election to your health care FSA (reduced by previous reimbursements) is available to you at all times during the calendar year. Thus, you may submit a claim for reimbursement of a health care expense even if you have not yet contributed enough to cover the entire amount of the claim submitted.

In contrast, the amount that you may be reimbursed from your dependent care FSA is limited to the amount you have contributed to date. If you have expenses greater than the amount accumulated in your dependent care FSA, they will be reimbursed automatically as additional contributions are credited to your FSA. You need not resubmit the claim.

Your health care FSA or dependent care FSA is reduced by any reimbursements made from the applicable FSA.

"Grace Period" for Regular-Purpose Health Care FSA

Generally, you may be reimbursed from a health care FSA only for expenses incurred while you contributed to that FSA for the Plan Year. **However, if you contributed to the general-purpose health care FSA as of the last pay period of the Plan Year, you will have an additional 2½ month "grace period" following the end of the Plan Year to incur eligible expenses to be reimbursed from the amounts remaining in your general-purpose health care FSA at the end of such Plan Year.** Any unused funds remaining in your general-purpose health care FSA at the end of the grace period will be forfeited.

Note: If you are enrolled in the general-purpose health care FSA and subsequently enroll in a high-deductible health plan ("HDHP") coverage option under the Medical Program for a future Plan Year, with a tandem election in a Health Savings Account ("HSA"), then you should consider spending your general-purpose health care FSA balance down to zero before the end of the Plan Year to avoid possible adverse consequences. Please contact the Claims Administrator if you should have any questions.

"Use It or Lose It"

Only expenses "incurred" during the coverage period are eligible for reimbursement from your FSA. Expenses are "incurred" when the care or services are provided. It does not matter when you are billed for an expense or when you pay for an expense. You may be reimbursed from a dependent care FSA only up to the amount that you have already contributed to that account for the Plan Year.

Forfeitures under each FSA for all employees participating in the FSA are used to cover the reasonable costs of administering the FSA Program, unless otherwise specified by the Plan Administrator or otherwise provided under an applicable collective bargaining agreement.

Remember, all claims for reimbursement must be received by the Claims Administrator or postmarked no later than midnight on April 30 following the end of the calendar year in which the expenses were incurred. Claims that are received or postmarked by then, but which are incomplete (for example, because the claim form is not signed or the claim lacks the proper supporting documentation) will not be processed.

Claims Eligible for Reimbursement from FSA After Participation Ends

General-Purpose Health Care FSA or Limited-Purpose Health Care FSA. After your participation is terminated, you may still be reimbursed from your Health Care FSA up to the amount of your total contribution election for the calendar year, less any previous reimbursements made to you. However,

you may be reimbursed only for eligible health care expenses that were incurred before the date your participation in the Flexible Spending Program ended.

Dependent Care FSA. Eligible dependent care expenses will be reimbursed up to the amount of your contributions to the Dependent Care FSA for the calendar year, less any previous reimbursements made to you. You may submit claims to be reimbursed for dependent care expenses that were incurred after your participation in the Dependent Care FSA ends but before the end of the calendar year in order to "spend down" your Dependent Care FSA.

Section 4. Reimbursable Health Care Expenses

Requirements of Eligible Health Care Expenses

You may be reimbursed for eligible health care expenses from your health care FSA. To be eligible for reimbursement, the health care expenses must:

- be incurred by you for you, your spouse, or your dependent during the Plan Year (plus grace period) to which the funds to be used for reimbursement relate;
- qualify as expenses incurred for "medical care" under Section 213 of the Code (see IRS Publication 502 for descriptions of expenses that qualify);
- not be reimbursable under any other health plan, flexible spending account or insurance; and
- if you participate in the limited-purpose health care FSA, be incurred **only for eligible dental and vision expenses**, such as (1) vision exams, LASIK surgery, contact lenses, and eyeglasses or (2) dental cleanings, X-rays, fillings, crowns, and orthodontia.

For purposes of the health care FSAs only, the definition of "dependent" includes certain individuals who are not dependents under the Company's other group health plans. "Dependent," for health care FSA purposes, includes the individuals described below who depend on you for at least half of their support:

- Your son or daughter (whether by birth, adoption, or placement for adoption) or a descendant of either (e.g., your grandchild);
- Your stepson, stepdaughter, brother, sister, stepbrother, stepsister, stepfather, stepmother, father or mother, or an ancestor of either, a niece, nephew, aunt, or uncle;
- Your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; and
- Any individual (such as a foster child) who lives in your home during the year and is dependent on you for at least half of his or her support.

If you are divorced, your child is considered to receive at least half of his or her support from both you and your ex-spouse regardless of who has custody. Thus, if you pay for health care expenses for that child, you can submit the expenses for reimbursement (even if your child does not live with you). Remember, your ex-spouse cannot also submit the same expense for reimbursement from any other health plan, flexible spending account or insurance.

Generally, qualified domestic partners do not qualify as dependents for purposes of determining eligible health care expenses of dependents.

Section 5. Reimbursable Dependent Care Expenses

Requirements of Eligible Dependent Care Expenses

You may be reimbursed for eligible dependent care expenses from your dependent care FSA. To be eligible for reimbursement, your dependent care expenses must meet all of the following requirements:

- the care must be provided to an "eligible dependent";
- the expenses must be for care provided primarily for the well-being and protection of the dependent (and not for educational or other purposes) or for household services which are incidental to the care of the eligible dependent;
- the care provider must meet certain requirements; and
- the care/household service must be necessary in order for you to work, and, if you are married, for your spouse to work or attend school full time (unless your spouse is disabled).

Eligible Dependent Defined

For the purpose of the dependent care FSA only, the following individuals are "eligible dependents":

- your child age 12 or younger for whom you are entitled to a dependent tax exemption for federal income tax purposes; and
- a disabled spouse or legal dependent who regularly spends at least 8 hours a day in your home.

If you are divorced, your child is an eligible dependent for purposes of the dependent care FSA only if you are the custodial parent. It does not matter in this situation whether you are entitled to claim the child as a dependent for federal income tax purposes.

Eligible Expenses

For dependent care expenses to be eligible for reimbursement, the dependent care must be provided primarily for the well-being and protection of the dependent. The care may be provided in your home or outside of your home (for example, in the home of the care provider or in a dependent care facility).

The following activities are considered to be for the well-being and protection of the dependent and are eligible for reimbursement: (1) general supervision, (2) bathing, (3) feeding, and (4) administering medicine.

Expenses for household services are also eligible for reimbursement if the services are for ordinary and usual tasks necessary for the maintenance of your home and are if they are at least partly for the well-being and protection of an eligible dependent. The following activities would meet this requirement: (1) cooking, (2) cleaning, (3) doing the laundry, and (4) general housekeeping.

Household services that are not eligible for reimbursement include such services as chauffeuring and gardening.

These household services might be provided by a housekeeper, baby-sitter, nanny, or maid. Household services provided by a person such as a gardener would not be eligible for reimbursement because the services of a gardener would not be attributable to the care of the dependent.

Ineligible Expenses

The following expenses are not eligible for reimbursement: (1) food, (2) clothing, (3) transportation, (4) entertainment, (5) education*, (6) overnight camp, (7) health care expenses (these expenses may be reimbursable through your health care FSA), and (8) expenses reimbursable under any other plan or program.

*Educational expenses (the cost of tuition in a private school) for grades kindergarten or higher are not eligible for reimbursement from the dependent care FSA. However, the cost of attending nursery school is eligible, because the primary purpose of nursery school has been determined to be the care of a child rather than the education of the child.

To ensure that your expenses are eligible for reimbursement according to IRS requirements, please refer to IRS Publication 503 (available at www.irs.gov), or consult your tax advisor.

Care Provider Requirements

For dependent care expenses to be eligible for reimbursement, the care provider must meet certain requirements. The care provider:

- must have a taxpayer identification number (Social Security number or employer identification number);
- cannot be your child under the age of 19;
- cannot be your spouse; and
- cannot be a person that you can or do claim as a dependent for federal income tax purposes.

A dependent care center is a facility that (i) provides care for more than six individuals who do not reside at the facility, and (ii) receives payment or a grant for providing the care.

If the care is provided at a dependent care center, then that facility must be a licensed care facility and must comply with all other applicable state and local laws and regulations.

See the "Eligible Dependent Care Expense Flow Chart" in the *Frequently Asked Questions* on the Plan Website for a helpful guide to determine if expenses qualify for reimbursement.

Section 6. Claims for Reimbursement and Appeal

Submitting a Claim for Reimbursement

During the calendar year, as you incur eligible expenses, you may submit claims for reimbursement. After the end of each calendar year, there is a final four-month period (January 1 through April 30) for submitting claims for expenses incurred during the calendar year. Claims and all supporting documentation must be received by the Claims Administrator by April 30. Claims received after April 30 or claims submitted by that date but without proper supporting documentation will not be paid. Any amounts remaining in your FSAs will be forfeited.

Please visit the Plan Website to submit a claim. (See the Contact Information Sheet to contact the Claims Administrator.) As a reminder, you must provide all required information and any receipts relating to the expenses incurred by April 30.

Appeals Procedures

If your entire claim is not paid, you have the right to appeal the denial to the Plan Administrator. Please see the Claims and Appeals Procedures in the Medical Program Chapter for how to file an appeal and to whom it must be sent.

Long Term Disability Program

The Long Term Disability ("LTD") Benefit is designed to offer you continuing income if you are unable to work during an extended period of disability. Your LTD Benefit is provided pursuant to a group insurance policy issued by the insurance company identified in the Contact Information Sheet.

Special Note for Pilots: The long term disability benefits for eligible pilots under the United Airlines Pilot Long Term Disability Plan ("Pilot LTD Plan") are provided under a disability plan that is separate from this Plan. Please consult the summary plan description for the Pilot LTD Plan for additional information.

Special Note for Non-Pilots: If a schedule for LTD is not included in the Schedule of Benefits attached to this SPD as an addendum, you are not eligible for Company-sponsored LTD benefits.

Section 1. LTD Benefits

Please see the Schedule of Benefits attached to this SPD as an Addendum. The Schedule of Benefits addresses the following key features of the LTD Benefit for your employee group:

- Eligibility and coverage
- Any contributions you must make to receive coverage
- The "elimination period" before benefits begin
- Important defined terms
- The benefit amount and certain offsets that apply
- Rules regarding your obligations to file claims for benefits, including specific rules for certain state disability programs
- How long benefits last
- Special rules if you return to work
- Limitations and exclusions from benefits

Filing a Claim

A claim for LTD Benefits must be made no later than 1 year following your original date of disability.

Section 2. Claims and Appeals Procedures

Your claim for long term disability benefits must be filed with the Claims Administrator, which is the insurance company identified in the Contact Information Sheet. After you submit a claim, the Claims Administrator will review your claim and notify you of its decision to approve or deny your claim.

Initial Determination

Written notice will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Claims Administrator, in which case the Claims Administrator may have up to two (2) additional extensions of 30 days each to provide you such notification. If an extension is needed, you will receive notice prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed) stating the reason why the extension is needed and when a determination will be made. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of the Claims Administrator's notice requesting further information and an extension until the Claims Administrator receives the requested information does not count toward the time period the Claims Administrator is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information.

If your claim is denied in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the

claim is denied because the Claims Administrator did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. The claims decision will provide a description of the Plan's appeals procedures and a statement of your right to file a civil action under Section 502 of ERISA following an adverse decision on appeal.

Appealing the Initial Determination

If your claim is denied, you may appeal the decision. Upon your written request, the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to the Claims Administrator at the address indicated on the claim form within 180 days of receiving an adverse decision on your initial claim. Appeals must be in writing and must include all required information.

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

Appeal Determination

After the Claims Administrator receives your written request appealing the initial determination, the Claims Administrator will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and the Claims Administrator's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination. The identity of the health care professional will be provided to you.

The Claims Administrator will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of your written request for review, except that under special circumstances the Claims Administrator may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, the Claims Administrator will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from the Claims Administrator's notice to you of the need for an extension to when the Claims Administrator receives the requested information does not count toward the time the Claims Administrator is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from the Claims Administrator.

If the claim is denied on appeal, the Claims Administrator will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. The final decision also will include a statement of your right to file a civil action under Section 502 of ERISA.

Section 3. Additional Restrictions

Legal Action

No legal action can be brought to recover under any benefit after the three-year anniversary of the date on which the Claims Administrator first requires proof of your claim. The Claims Administrator will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than two years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

You must use and exhaust this Plan's administrative claims and appeals procedure before bringing a suit in either state or 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 regarding an adverse benefit determination.

Lien and Repayment

If you receive disability benefits under the Plan and you receive payment from a third party for the same loss of income (for example, a judgment, settlement, payment from Federal Social Security or payment pursuant to Workers' Compensation laws), you will need to reimburse the Claims Administrator from the proceeds of such payment up to the value of the disability benefits paid to you. The Claim Administrator's right to receive reimbursement will be a first priority claim or lien against such proceeds. You must take all action necessary to enable the Claims Administrator to exercise its rights under this provision, including, without limitation:

- notifying the Claims Administrator as soon as possible of any payment you receive or are entitled to receive from a third party for the same loss of income for which you received disability benefits;
- furnishing of documents and other information as requested by the Claims Administrator or any person working on its behalf; and
- holding in escrow (or causing your legal representative to hold in escrow) any such proceeds paid to you or any party by a third party, up to the value of the disability benefits paid to you, to be paid immediately to the Claims Administrator.

You must cooperate with the Claims Administrator in any recovery efforts and not interfere with its rights under this provision. The Claims Administrator's rights under this provision apply whether or not you have been or will be fully compensated by a third party for any disability for which you received or are entitled to receive disability benefits.

Life and Accident Insurance Program

The Life and Accident Insurance Program is designed to provide insurance coverage to help your family meet their financial needs in case of your death or the death of an eligible family member. The Program also provides Personal Accident Insurance ("PAI") benefits if you suffer an accidental dismemberment (such as the loss of a limb or your eyesight), as well as benefits for certain accidental death events or injuries that happen either on or off the job.

The Life and Accident Insurance Program benefits are provided under one or more insurance policies issued by the insurance company(ies) identified in the Contact Information Sheet.

Section 1. Life and Accident Benefits

Please see the Schedule of Benefits attached to this SPD. The Schedule of Benefits addresses the following key features of the Life and Accident Insurance Program for your employee group:

- Eligibility and coverage
- Any contributions you must make to receive insurance coverage
- Minimum and maximum insurance benefits
- Special rules for accelerated distributions for terminal illnesses, conversion and portability of coverage, and coverage continuation if you are disabled or take a leave of absence
- Limitations and exclusions from benefits
- How you can obtain additional detailed information regarding the benefits under the Life and Accident Insurance Program

Section 2. Beneficiary Designations

You will be provided with a beneficiary designation form for your life insurance coverage which you should complete on-line via the Plan Website. If at any time you wish to change your beneficiary designation, please visit the Plan Website or the website maintained by the insurance company. You may also contact the insurance company to receive a paper beneficiary designation form.

If there is no designated beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid in accordance with the default beneficiary procedures specified in the applicable insurance policy. As a result, to ensure that death benefits are paid in accordance with your wishes, you must complete the beneficiary designation form in accordance with the Plan's procedures.

Section 3. Claims and Appeals Procedures

Your claim for benefits under any of the life and accident benefits must be filed with the applicable insurance company indicated on the Contact Information Sheet.

Time Frames and Procedures for Initial Claim Decision

You will receive a written notice of the final decision on your claim within 90 days after you file it. Under special circumstances, the time period for making a decision may be extended to 180 days. In this case, you will be notified of the extension within 90 days after you file your claim. If your claim is denied completely or in part, the notice will explain the reason for the denial and refer to the specific Life and Accident Insurance Program provisions on which the denial is based. It will also tell you what additional information may be needed to process your claim and why it is necessary, and will review the appeal procedure.

Time Frames and procedures for Appealing the Initial Determination

You are entitled to appeal a denial of your claim, and to review, and obtain copies of, free of charge, any relevant documents. Appeals must be made in writing within 60 days from the date you receive the notice of denial of your claim. You should send your written appeal in accordance with the appeal procedures which accompanied your claim denial. You may submit written issues and comments along with your appeal.

You will receive a written decision on your appeal within 60 days of the date it is received, unless special circumstances requiring an extension are necessary. In this case, you will receive a written notice of the extension, which may not be more than 120 days after the date of your appeal is received.

The written notice of the decision will inform you of the specific reasons for the decision and the specific provisions of the Life and Accident Program upon which the decision is based. Upon written request, the Plan Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. The final decision also will include a statement of your right to file a civil action under Section 502 of ERISA.

Benefits After Retirement

Depending on your employee group, you may be eligible for benefits after retirement. **See the Schedule of Benefits attached as an Addendum to this SPD.**

If you satisfy the applicable eligibility requirements for the Benefits After Retirement Program at the time you retire from the Company, you will be provided a separate summary plan description describing the post-retirement benefits available to you.

Subject to the terms of any applicable collective bargaining agreement, the Company reserves the right to modify, amend, or terminate any benefits after retirement at any time and for any reason without prior notice.