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

Effective January 1, 2018

About This Guide

Envoy Air, Inc. (the "Company") provides you with a comprehensive benefits package designed to help you meet the health, life, accident, disability, and dependent care needs of you and your eligible family members. To help you make the most of those benefits, this Employee Benefits Guide (the "Guide" or "EBG") describes the provisions of the Group Health and Welfare Benefits Plan for Employees of Envoy Air Inc. and Its Affiliates (the "Plan") effective January 1, 2018.

The provisions of this Guide apply to eligible employees on the United States payroll, spouses, dependents, and surviving spouses who elect coverage of the Company, Eagle Aviation Services, Inc., and Executive Airlines, Inc. (collectively, the "Affiliates"). The provisions of this Guide do not apply to employees of Envoy Ground Services

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

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

Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and an insurance policy/evidence of coverage, or this Guide, the Plan Document controls. If the Plan Document is silent, then the Guide controls, except where the Guide refers to an insurance policy/evidence of coverage. If both the Plan Document and Guide are silent, the terms of the applicable insurance policy/evidence of coverage controls, except where this Guide refers to an insurance policy/evidence of coverage. If both the Plan Document and this Guide are silent, the terms of the applicable insurance policy/evidence of coverage controls. However, with respect to fully insured benefits, the terms of the certificate of insurance or insurance policy/evidence of coverage control when describing specific benefits that are covered or insurance-related terms. See the chapter "Reference Information" to determine whether a particular benefit is self-funded by the Company or fully insured by the insurer. The Company, or its authorized delegate, reserves the right to modify, amend or terminate any of the Plans, any program described in this Guide, or any part thereof, at its sole discretion, except as otherwise specified in the Collective Bargaining Agreements. You will be notified of any changes that affect your benefits, as required by federal law.

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

Only the Company or the Envoy Benefits Administration Committee ("EBAC") is authorized to change the Plan. From time to time, you may receive updated information concerning changes to the

Plan. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment, or benefits of any kind.

Contents

Benefits at a Glance

The Plan will include the following benefits for 2018:

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

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

Type of Benefit	Self-Funded or Insured	Administrator or Insurer	Funding Mechanism
Long Term Disability	Insured	The Hartford	Employee-Paid Premiums
FLEXIBLE SPENDING ACCOUNTS (FSAs)			
Health Care FSA	Self-funded	Alight Solutions	Employee-Paid Contributions
Dependent Day Care FSA	Self-funded	Alight Solutions	Employee-Paid Contributions
HEALTH SAVINGS ACCOUNT (HSA)**	Self-funded	OptumBank	Employee-Paid Contributions
CRITICAL ILLNESS	Insured	AllState	Employee-Paid Premiums
EMPLOYEE ASSISTANCE PROGRAM	Self-Funded	Espyr	General Assets of the Company
LEGAL SERVICES	Insured	Metlaw/Hyatt	Employee-Paid Premiums

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

** This benefit is not sponsored by the Company.

General Eligibility

Eligible Employees

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

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

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

If you do not enroll for coverage when you are first eligible for benefits, you will receive no coverage. Your next opportunity to enroll will be during the annual open enrollment period for the following year or, if earlier, the date you experience a qualified Life Event.

For coverage requiring Proof of Good Health, coverage becomes effective only after coverage is approved and your first contributions are paid by you through payroll deductions.

Shortly following the start of employment at the Company, you will be able to enroll online through the employee portal (my.envoyair.com) or call the Benefits Service Center to enroll over the phone at 844-843-6869. For more information about enrollment, see *General Enrollment*.

Hours Worked Requirement for Fleet Service Clerks and/or Agents

Newly Hired Employees

Effective January 1, 2015, newly hired employees will be eligible to enroll in benefits after one month of employment and will continue to be eligible for benefits through the end of the year in which the first anniversary of their start date occurs. Thereafter, if they were hired on or before October 3rd, they will be treated as "ongoing employees" and their eligibility and contribution rates will be determined based on their Eligible Hours during the period from October 3rd to October 2nd of the preceding year (the "Look Back Period"). If they were hired after October 3rd, they will remain eligible for coverage through the end of the calendar year in which the second anniversary of their state date occurs, and their rate will be based on their prorated hours over the Look Back Period.

For example, a Fleet Service Clerk or Agent hired on March 3, 2017 will be eligible for benefits on April 3, 2017 and will remain eligible through December 31, 2018. The annual analysis of Eligible Hours performed prior to the annual enrollment occurring in fall 2018 will review the Eligible Hours

credited from October 3, 2017 through October 2, 2018 to determine eligibility for coverage during 2019.

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

- From the date of hire through the end of that calendar year, employees will pay the rate according to their hire classification (e.g., Part-time or Full-time).
- For the calendar year following the date of hire, employees who are hired after July 3rd (i.e., less than 90 days before the end of the Look Back Period) will continue to pay the contribution rate according to their hire classification.
- For the calendar year following the date of hire, employees who are hired on or before July 3rd (i.e., 90 days or more before the Look Back Period) will have their Eligible Hours prorated to determine the contribution rate for the next year.
- For the second calendar year following the date of hire, employees who are hired after October 3rd will have their Eligible Hours prorated to determine the contribution rate.

For example, a Fleet Service Clerk or Agent hired on August 3, 2017 and classified as part-time will pay the part-time employee contribution rate for 2017 and 2018. In contrast, a Fleet Service Clerk or Agent hired on March 3, 2017 and classified as part-time will pay the part-time employee contribution rate for 2017, and the rate for 2018 will be determined based on whether he/she was full-time or part-time based on a prorated number of hours worked from March 3, 2017 through October 2, 2017.

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

Ongoing Employees

Effective with the Plan year beginning January 1, 2014, for calendar years beginning after the first anniversary of their start date (or, for Fleet Service Clerks and Agents hired after October 3rd, the second anniversary of their start date), after the second anniversary of their start date, Fleet Service Clerks and Agents must have worked 800 or more Eligible Hours during the Look Back Period to be eligible for coverage under the Plan. For example, the annual analysis of Eligible Hours performed prior to the annual enrollment occurring in fall 2017 (for the 2018 calendar year) will review the Eligible Hours credited from October 3, 2016 through October 2, 2017. Any Fleet Service Clerk or Agent who meets the appropriate Eligible Hours requirement during the Look Back Period will be eligible to enroll in benefits during the annual enrollment period for coverage during 2018.

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

Hours Worked Requirement for Flight Attendants

Newly Hired Employees

Effective January 1, 2015, newly hired employees will be eligible to enroll in benefits after one month of employment and will continue to be eligible for benefits through the end of the year in which the first anniversary of their start date occurs. Thereafter, if they were hired on or before October 3rd, they will be treated as "ongoing employees" and their eligibility and contribution rates will be determined based on their Flight Attendant Eligible Hours during the Look Back Period. If they were hired after October 3rd, they will remain eligible for coverage through the end of the calendar year in which the second anniversary of their start date occurs, and their rate will be based on their prorated hours over the Look Back Period.

For example, a Flight Attendant hired on March 3, 2017 will be eligible for benefits on April 3, 2017 and will remain eligible through December 31, 2018. The annual analysis of Flight Attendant Eligible Hours performed prior to the annual enrollment occurring in fall 2018 will review the Flight Attendant Eligible Hours credited from October 3, 2018 through October 2, 2017 to determine eligibility for coverage during 2019.

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

- From the date of hire through the end of that calendar year, employees will pay the rate according to their hire classification.
- For the calendar year following the date of hire, employees who are hired after July 3rd (i.e., less than 90 days before the end of the Look Back Period) will continue to pay the rate according to their hire classification for that year.
- For the year following the date of hire, employees who are hired on or before July 3rd (i.e., 90 days or more before the end of the Look Back Period) will have their Flight Attendant Eligible Hours prorated to determine the contribution rate for the next year.
- For the second calendar year following the date of hire, employees who are hired after October 3rd will have their Eligible Hours prorated to determine the contribution rate.

For example, a Flight Attendant hired on August 3, 2017 and classified as part-time will pay the part-time employee contribution rate for 2017 and 2018. In contrast, a Flight Attendant hired on March 3, 2017 and classified as part-time will pay the part-time employee contribution rate for 2017, and the rate for 2018 will be determined based on the prorated number of Flight Attendant Eligible Hours credited from March 3, 2017 through October 2, 2017. "Flight Attendant Eligible hours" are outlined in the applicable Collective Bargaining Agreement.

Ongoing Employees

Effective with the Plan year beginning January 1, 2014, for calendar years beginning after the second anniversary of their start date, (or, for Flight Attendants hired after October 3, the second anniversary of their start date), Flight Attendants that worked between 350 and 539 Flight Attendant Eligible Hours during the Look Back Period, prorated in accordance with the applicable Collective Bargaining Agreement, will be eligible for Company-subsidized health benefits at the part-time

employee contribution rate. Flight Attendants who worked 540 or more Flight Attendant Eligible Hours during the Look Back Period will be eligible for Company-subsidized health benefits at the full-time employee contribution rate. For example, the annual analysis of Flight Attendant Eligible Hours performed prior to the annual enrollment occurring in fall 2017 (for the 2018 calendar year) will review the Flight Attendant Eligible Hours credited from October 3, 2016 through October 2, 2017. Any Flight Attendant who meets the appropriate Flight Attendant Eligible Hours requirement during the Look Back Period will be eligible to enroll in benefits during the annual enrollment period for coverage during 2018.

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

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

Eligibility After Age 65

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

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

Ineligibility

None of the following individuals are eligible to participate in the Plan:

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

Dependent Eligibility

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

Medical Coverage

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

- Spouse.
- Child under age 26. See "Determining a Child's Eligibility" below for who qualifies as a "child."
    - Step-children.
    - Legally adopted children.
    - Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.
- Incapacitated child age 26 as described below.

Coverage for an Incapacitated Child – Medical Coverage Only

An Incapacitated Child age 26 or older is eligible for continuation of coverage if all of the following criteria are met:

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

Dental and Vision Coverage

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

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

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

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

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

The term does not include any person who:

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

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

- Your natural child, adopted child or stepchild who is under age 25 and unmarried.

The term also includes:

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

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

The term does not include any person who:

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

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

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

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Stepchild
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" in the Additional Health Benefit Rules section).
- Special Dependent, if you meet all of the following requirements:
    - You must have legal custody and legal guardianship of the child.
    - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support
    - You must submit a Special Dependent Statement**,** available under Health & Welfare forms on the benefits page on my.envoyair.com**,** to the Benefits Service Center and the Benefits Service Center must approve the form. (Complete and return the form to the Benefits Service Center, along with copies of the official court documents awarding you custodianship or guardianship of the child.) You must receive confirmation from the Benefits Service Center notifying you of its determination.
        - The Benefits Service Center will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 30 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by the Benefits Service Center. If you submit the request after the 30-day time frame, the child will not be added to your coverage.

Parents and Grandchildren

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

Dependents of Deceased Employees

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

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

Proof of Dependent Eligibility

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

Whether you:

- enroll dependents when you are first eligible to enroll in benefits, or
- enroll new dependents at annual enrollments, or
- enroll new dependents as the result of a Life Event,

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

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

Determining a Spouse, Common Law Spouse's Eligibility

Throughout this Guide, the term "spouse" is used to refer to your legally married spouse (of the same or opposite sex spouse). **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).**

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

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

Special Rules that Apply to Employees Married to Other Employees

Employees Married to Other Employees

When two employees are married to each other, they are referred to as "Married Employees" for this section. Married employees have the option of being covered as: (1) two single employees, each with

their own employee coverage, or (2) under one employee's Medical, Dental and/or Vision benefits as an employee and a dependent. Married employees may elect to be covered under one employee's benefits during Annual Enrollment or at the time of a qualified Life Event (if the qualified Life Event allows such a change). If one employee decides to be covered under the other employee as a dependent, the employee covered as a dependent spouse, will not receive the company provided AD&D and Basic Life insurance, which is automatically provided to employees enrolled as employees in medical coverage.

Change in spouse's employment: If one spouse ends his or her employment with the Company, such individual is eligible for coverage as a dependent (if he or she waives coverage under the Company's health benefits). However if an employee is discharged for gross misconduct he or she cannot be covered as a dependent of the active employee.

Spouse not eligible for full benefits: During the one-month waiting period required to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits.

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

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

The actively working spouse may elect to:

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

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

- Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave
- Proof of good health may be required to re-enroll or increase optional coverages upon the employee's return to work.

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

Other Information

Eligible dependent children*:* If both spouses are covered under the Group Health and Welfare Benefits Plan, eligible dependent children are covered as dependents of the parent whose birthday

occurs first in the calendar year, unless the parents elect otherwise. Contact the Benefits Service Center at 844-843-6869 to change this requirement. Children cannot be covered under both parents' health benefits. See "Dependent Eligibility"

Contributions: If both you and your spouse are covered independently under the Group Health and Welfare Benefits Plan and select exactly the same medical or dental option at the same cost, your contributions will be adjusted to ensure you pay approximately the same for your total family coverage as you would if your spouse worked elsewhere. The savings will be divided equally and applied to both your paychecks.
Family Deductibles: Family Deductibles (described under "Key Features of the Medical Benefit Options" in the *Medical* section) apply if both employees choose the same medical option. If the parents choose different options, the family Deductible applies to the employee covering the children and the individual Deductible applies separately to the other parent.

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

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

Flexible Spending Accounts: Deposits to the Health Care, Limited Purpose, and Dependent Day Care Flexible Spending Accounts (see the *Health Care FSA and Limited Purpose Flexible Spending Account* and the *Dependent Day Care FSA* sections) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one spouse is making deposits to the account, claims must be submitted under that person's Social Security number. If you both make deposits, you may only contribute the maximum amount the law permits for a couple filing a joint tax return.

Working Spouse's Surcharge

Starting on January 1, 2017, the Company will assess a surcharge of $100 per month (the "Spousal Surcharge") for spouses covered under the Group Health and Welfare Benefits Plan that have access to their own employer's medical coverage. The Spousal Surcharge will not apply to spouses employed by Envoy or an Affiliate, but will apply to spouses employed by another American Airlines Group company. All employees electing benefits for the first time who wish to cover a spouse under the Plan will need to access the online Benefits Service Center during the enrollment process to certify whether their spouse has access to medical coverage through his or her employer. If your spouse is unemployed or does not have access to medical coverage through their employer, you will need to certify this online during the enrollment process so that the Spousal Surcharge is not applied

to your coverage in 2018. **If you do not take any action to certify your spouse during annual enrollment, your spousal certification from prior years will default annually.**

If your spouse loses coverage during the plan year, you will need to contact the Benefits Service Center and certify your spouse has lost access to medical employer coverage. Once the certification process is completed, the Spousal Surcharge will be removed. If at a later date your spouse is re-employed and gains access to employer-sponsored medical coverage again, you will need to contact the Benefits Service Center and re-certify your spouse.

General Enrollment

New Employee Enrollment

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

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

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

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

Current Employees

Annual Enrollment

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

the exception of specific Life Events, annual enrollment is the only time you can change your coverage elections.

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

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

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

You must complete a Personal Health Application form from The Hartford within 30 days after the close of annual enrollment. For example, if during annual enrollment for the 2018 benefit year you elect to increase the amount of your employee term life insurance for 2018, you must submit your Personal Health Application form to The Hartford no later than 30 days after the annual enrollment period ends. If your statement is submitted more than 30 days after the close of annual enrollment, your application for this coverage will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for the coverage.

Please Be Aware of These Important Points:

The annual enrollment period occurs each fall.

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

Annual Enrollment

Annual Enrollment

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

requirements are listed on my.envoyair.com, under Benefits, in the Resources site, or you may contact the Benefits Service Center for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section).

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

Newly eligible employees who do not complete the enrollment process will not be enrolled in any benefits. Your next opportunity to enroll will be during the annual open enrollment period for the following year or, if earlier, the date you experience a qualified Life Event.

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

Default Medical Coverage for Current Employees

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

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

Benefit	Default	Comments
Medical Benefit Option	PPO 750, PPO 1500, PPO 2500	If your current medical benefit option is not available in your location, you and your eligible dependents will be enrolled in the Out-of-Area option. Employees with a Puerto Rico address will default to the PPO 750 option.
Flexible Spending Account Benefits (Health Care FSA, Dependent Day Care FSA)	No coverage	Your FSA accounts will default to $0.00 unless you enter an amount.

Waiving Coverage

You may choose to waive coverage if you do not want to participate in the Plan. Please keep in mind that your dependents will not receive coverage unless you are covered. If you waive coverage, you can enroll in coverage later in the year only if you experience a qualifying Life Event such as marriage, divorce or the birth or adoption of a child.

How to Enroll

Follow these steps to enroll before your enrollment deadline:

Step 1: Visit the Benefits page on my.envoyair.com

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

Step 2: Review your dependents

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

Step 3: Enroll

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

Coverage Levels

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

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

When Coverage Begins

If you enroll by the enrollment deadline, your elected coverage is retroactive to the date you are first eligible for benefits and your paycheck is adjusted as necessary.

Paying for Coverage

Each year the Company reviews the benefit options offered to employees and the cost of each plan. Based on your employment status and the number of family members enrolled in your coverage, you

pay a specified amount towards the cost of your benefits, and, for certain benefits, the Company pays the rest as described below. Once you have completed one month of Company service, the Company pays a portion of the cost of your medical and dental coverage; you pay the remaining amount of the actual cost for providing these benefits. Your contributions are fixed premium obligations and you will not be entitled to any reduction or refund of your contributions (including, without limitation, applicable Deductibles or co-payments) in the event that the claims experience of the Plan is more favorable than projected or the Plan receives any discount, refund, rebate, settlement or damages pursuant to an agreement with or settlement or judgment with or from an insurer, any medical Provider or other organization or individual.

Company-Subsidized Benefits

All eligible employees are provided with basic benefits protection that is subsidized by the Company. These benefits include:

- **Medical Benefits.** You can choose from PPO 750, PPO 1500, PPO 2500 or an Out-of-Area option, if you do not live within a PPO plan service area. Your contributions fund a portion of the cost with the Company covering the rest.
- **Dental Benefit.** You contribute a portion of the contribution cost with the Company covering the rest.
- **Basic Life Insurance & Accidental Death and Dismemberment Insurance –** The Company provides coverage based on 1 times your annual salary for benefits (if enrolled in medical) without charge to you.

Employee-Paid Benefits

You can also select from a number of optional benefits for which you pay the full cost. These include:

- Vision Insurance
- Voluntary Term Life Insurance
- Voluntary Personal Accident Insurance
- Optional Short Term Disability Insurance
- Long Term Disability Insurance
- A Health Care Flexible Spending Account
- A Dependent Day Care Flexible Spending Account
- Critical Illness Insurance
- Legal Services
- Health Savings Account (HSA)*

* The Health Savings Account is not a Company-sponsored plan or benefit option.

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

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

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

Taxation of Benefits

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

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

Type of Benefits	Before-Tax?	May Waive?
Medical Benefit Options (for employee and tax dependents) ▪ PPO 750 Option ▪ PPO 1500 Option ▪ PPO 2500 Option ▪ Out of Area Option	Yes	Yes*
Vision Insurance Benefit	Yes	Yes
Voluntary Term Life Insurance Benefit (below $50,000)	Yes	Yes**
Voluntary Personal Accident Insurance Benefit	No	Yes
Spouse Term Life Insurance Benefit	No	Yes**
Child Term Life Insurance Benefit	No	Yes
Optional Short Term Disability Insurance Benefit	No	Yes**
Long Term Disability Insurance Benefit	No	Yes**
Health Care Flexible Spending Account Benefit	Yes	Yes***
Dependent Day Care Flexible Spending Account Benefit	Yes	Yes
Critical Illness	No	Yes*
Dental Benefit Option	Yes	Yes*
Legal Services	No	Yes

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

** Requires Proof of Good Health any time you increase your level of coverage or if you waive coverage and later decide to elect it.

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

When Coverage Ends

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

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

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

- The date this Plan or benefit option terminates
- The last day for which your spouse's contribution has been paid
- The date he or she is no longer your spouse
- The date you are no longer eligible for this Plan or benefit option
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan or benefit option.
- The date your surviving spouse remarries

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

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

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

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

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

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

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

If you are eligible, you can generally take up to 26 workweeks of job-protected "military caregiver leave" during a single 12-month period to care for a covered service member with a serious injury or illness if you are the spouse, son, daughter, parent, or next of kin of the "covered service member." Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

FMLA for Airline Flight Crewmembers

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

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

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

Unpaid Sick or Injury on Duty Leave of Absence

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

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

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

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

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

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

IMPORTANT: If you elect not to continue your benefits while on your leave, or if you fail to timely pay the required monthly contributions for coverage, your benefits will terminate for the duration of your leave of absence unless you are no longer eligible for coverage due to failure to satisfy the hours for Flight Attendants, Fleet Service Clerks, and Agents (e.g., if your leave crosses calendar years). When you return to active status, you may reactivate most of your benefits; however, some benefits will require that you supply Proof of Good Health in order to reactivate them (i.e., Long Term Disability Insurance, Optional Short Term Disability Insurance, and Voluntary Term Life Insurance).

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

Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was

interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

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

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

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

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

For more information regarding your rights under USERRA, visit https://www.dol.gov/vets/programs/userra/.Life Events and Special Enrollment Rights: Making Changes During
the Year

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

HIPAA Special Enrollment Rights – Medical Benefit Option Only

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

You and/or your dependents lose the other medical coverage because:

- eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- the employer contributions to the other coverage have stopped.
- the other coverage was COBRA and the maximum COBRA coverage period ends.
- you and/or your dependents exhaust a lifetime maximum in another employer's health plan or in other health insurance coverage.

- Your employer and/or your dependent's employer cease to offer health benefits to the class of employees through which you (or one of your dependents) have coverage.

You acquire a new dependent because of:

- Your marriage or your child's birth, adoption, or placement for adoption with you.

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

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

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

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

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

Keep in mind that if you are adding dependent(s) to your benefits during this special enrollment period, you must submit proof that these dependents qualify as your eligible dependents, and submit proof of loss of Medicaid or CHIP coverage, or proof of eligibility for the state premium assistance (under Medicaid or CHIP). Proof that the dependents you enroll qualify as your eligible dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, etc., as described in the Proof of Eligibility Requirements.

Life Event

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

You must register the Life Event and submit proof of the dependent's eligibility within 30 days of the event with the Benefits Service Center. **If you miss the 30 day deadline, your Life Event change will not be processed.** You will have to wait until the next Annual Enrollment Period to make changes to your benefits. You can appeal any denial of eligibility if there are extenuating circumstances. See the appeals section in [COMPLETE].

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

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

However, if your dependent(s) lose eligibility under the Plan, you must contact the Benefits Service Center to remove the ineligible dependent(s) from coverage – even if you have missed the 30-day deadline. If you contact the Benefits Service Center after the 30-day deadline you will be able to remove your dependent(s) from coverage, but the effective date of the removal will be the date you notified us, and your resulting contribution rate changes, if any, will be effective as of the date you notified the Benefits Service Center. You may not receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified the Benefits Service Center of their ineligibility. Refunds are determined upon a case-by-case basis. Keep in mind that if you do not notify the Benefits Service Center of your dependent(s)' eligibility within 60-days of the date of the loss of eligibility, the dependent(s) will lose their right to continue coverage under COBRA, so it is important that you are timely in registering your dependent(s)' removal from coverage within the 60-day timeframe.

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

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

- Any change in your cost for coverage applies on the date the change is effective. Catch-up contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.
- You cannot enroll your dependents for coverage if you are not covered.
- You may start or increase a Health Care Flexible Spending Account only if you have enrolled a dependent that was not previously covered. Starting or increasing either Life, Accident, or

Disability insurance may require Proof of Good Health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance. When you add Life or Accident Insurance, you must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations, and you can make beneficiary changes on the Benefits Service Center. Once you complete and submit the online **Beneficiary Designation Form**, it supersedes all previous designations.

- If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment Insurance that will be paid is your "default coverage." If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.
- You or your spouse may only increase your Life Insurance coverage by one level per year, with Proof of Good Health.
- If you elect to enroll in any coverage requiring Proof of Good Health, you must submit (postmarked) a completed, dated, and signed Personal Health Application from The Hartford within 30 days after your enrollment/election date. If your statement of health is not postmarked within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

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

Table of Life Events and Permitted Benefit Changes

This table describes the changes you may make when certain Life Events occur.

If…	Then, You Can…
You become eligible for Company-provided benefits	Enroll online through the Benefits Service Center.
You get married	▪ **Medical Benefit Options:** Add coverage for your spouse and eligible dependents; stop coverage for a dependent or yourself. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum will not carry over to your new Medical Benefit Option**. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage, however this coverage applies to the employee only. ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your spouse and/or child, or increase or decrease existing employee coverage. ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Accounts Benefits:** Start Flexible Spending Accounts; increase Flexible Spending Account contributions. ▪ **Health Savings Account:** You can start contributions to a HSA, provided you and your spouse are enrolled in the PPO 1500 or PPO 2500 Benefit Option. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You divorce or legally separate, ***or*** ***You obtain a protective order***	▪ **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for your spouse. Add coverage for yourself and/or your eligible dependents (dependent coverage may be subject to QMCSO—see "Qualified Medical Child Support Order" in the *Additional Health Benefit Rules* section). You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your spouse and/or child, or increase or decrease existing employee coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for yourself; stop coverage for spouse or child; increase or decrease existing employee coverage ▪ **Flexible Spending Accounts Benefits:** Start/stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. ▪ **Health Savings Account:** You may start or stop contributing, if you are enrolled in the PPO 1500 or the PPO 2500 medical option. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You or your spouse becomes pregnant	▪ This does not permit you to make any changes in your benefit elections until the baby is born

If…	Then, You Can…
You or your spouse gives birth or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household	▪ **Medical and Dental Options and Vision Insurance Benefit:** Start/add coverage for the dependent(s) and yourself, and/or your spouse. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum <u>will not</u> carry over to your new Medical Benefit Option**. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your child, increase or decrease existing coverage for you with Proof of Good Health ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. ▪ **Health Savings Account:** You may start contributing to a HSA if you are enrolled in the PPO 1500 or the PPO 2500 medical option. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

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

If…	Then, You Can…
Your spouse or dependent dies	▪ **Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible spouse or dependent. You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible dependent; increase or decrease existing coverage for you with Proof of Good Health. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Stop coverage for your eligible spouse or dependent or start or stop coverage for yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. ▪ **Health Savings Account:** You may contribute to an HSA, if you are enrolled in the PPO 1500 or the PPO 2500 Benefit Option. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
Change in spouse's employment or other health coverage ***OR*** ***spouse's employer no longer contributes toward health coverage*** ***OR*** ***Your spouse's employer no longer covers employees in your spouse's position***	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse, your eligible dependent or yourself; stop coverage for your eligible spouse, eligible dependent or yourself. You cannot change benefit plans at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible spouse or eligible dependent in the applicable benefit option. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. ▪ **Health Savings Account:** You may contribute to an HSA, if you are enrolled in the PPO 1500 or the PPO 2500 Benefit Option. ▪ Critical Illness Plan: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You and/or your eligible dependent(s) declined Company medical coverage because you or they had coverage elsewhere (external to Company), and any of the following events occurs, you have 30 days from the date of the event to enroll yourself and/or your eligible dependents in a Medical Benefit Option: ▪ Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) ▪ Employer contributions for the other coverage stopped ▪ Other coverage was COBRA and the maximum COBRA coverage period ended ▪ Exhaustion of the other coverage's lifetime maximum benefit ▪ Other employer-sponsored coverage is no longer offered ▪ Other coverage ends because you and/or your eligible dependents no longer reside, live, or work in its service area ▪	You have 30 days from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you. **This event allows you to add coverage under a Medical Benefit Option only.**

If…	Then, You Can…
You or your dependent exhausts a lifetime limit in another medical plan	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

If…	Then, You Can…
You become disabled	▪ **Notify:** Your supervisor and call The Hartford to initiate a disability claim (if enrolled) ▪ **Complete and submit:** Your claim for disability benefits
You take a leave of absence	▪ **You will receive:** A personalized Leave of Absence Worksheet from the Benefits Service Center when the payroll transaction placing you on unpaid leave is processed. The worksheet lists your options during the leave, cost for benefits coverage, and the election deadline. ▪ **Your cost depends on:** The type of leave you are taking
You return from an unpaid leave of absence	▪ **Medical and Dental Options and Vision Insurance Benefit:** Resume coverage. You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage; increase or decrease existing employee coverage. ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Accounts Benefits:** Resume Flexible Spending Account contributions. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You change from part-time to full-time or full-time to part-time*	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent, or increase or decrease existing coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You die	▪ **Continuation of Coverage:** Your dependents should contact your supervisor, who will coordinate with Envoy Survivor Support to assist with all survivor benefits and privileges. The Benefits Service Center will send information, including the election of Continuation of Coverage, if applicable.
You end your employment with the Company	▪ **Review:** When Coverage Ends within this Guide ▪ **Review:** The information you receive regarding Continuation of Coverage through COBRA ▪ **Contact: The Benefits Service Center** for information
You transfer to another work group or subsidiary of American Airlines Group	**Contact:** Your supervisor, the Benefits Service Center, or the new subsidiary to determine benefits available to you and to make new benefit elections
Benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")	**Make changes to the applicable benefit coverage:** The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.

If…	Then, You Can…
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child	**Medical and Dental Options and Vision Insurance Benefit:** Start or add coverage for the dependent(s) and yourself. You cannot change benefit options at this time.
You, your spouse or your dependent enroll in Medicare or Medicaid	**Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for the applicable person. You cannot change benefit options at this time.
You or your dependent(s) lose Medicaid or CHIP coverage	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. If you are already enrolled in Medical, Dental, and Vision Options and are adding dependents, you cannot change medical or dental options at this time. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: No changes allowed at this time. ▪ **Legal Services Plan**: No changes allowed at this time.
You or your dependent(s) become eligible for a state premium assistance program (under Medicaid or CHIP)	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum <u>will not</u> carry over to your new Medical Benefit Option**. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: No changes allowed at this time. ▪ **Legal Services Plan**: No changes allowed at this time.

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

Life Event Considerations

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

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

Stepchild: You may add coverage for a stepchild if the child lives with you and you the employee, either jointly or individually, claim the stepchild as a dependent on your federal income tax return. However, for coverage in a Medical Benefit Option, all stepchildren are eligible for coverage up to age 26 regardless of residence or tax status.

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

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

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

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

Benefit Coverage Affected by Life Events

Voluntary Term Life Insurance Benefit: You may only increase this coverage by one level per year with approved Proof of Good Health.

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

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

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

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

Benefit Coverage Not Affected by Life Events

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

Medical Benefit Options: If you are enrolled in the PPO 750, PPO 1500, PPO 2500 or Out-of-Area Option, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in your new location.

Medical Benefits Overview

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

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

- PPO 750 Option
- PPO 1500 Option
- PPO 2500 Option
- Out-of-Area Option*

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

*** Out-of-Area Option**

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

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

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

PPO 750, PPO 1500 and PPO 2500 Options

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

You may decide whether to use Network or out-of-Network Providers each time you need care under the PPO 750, PPO 1500 and PPO 2500 Options. Under the PPO 750 Option, when you use a Network Provider, you pay only a Copayment or 20% Coinsurance after Deductible for most services provided by a Network Provider (with the exception for preventive care). Under the PPO 1500 and PPO 2500 Options, you pay 20% Coinsurance after satisfaction of the Deductible for services provided by a Network Provider. A Deductible is required for any Coinsurance-based services under the PPO 750, PPO 1500, and PPO 2500 Options. You may enroll in the Health Savings Account if you elect either the PPO 1500 and the PPO 2500 Options.

If you go to a Provider who is not part of the Network, you are still covered for eligible, Medically Necessary services, but at a lower level of benefits, called the out-of-Network benefit level. At the out-of-Network benefit level, you pay a higher Deductible and higher out-of-pocket amounts. For most out-of-Network services, the plan pays 60% and you pay the remaining 40% after you satisfy the Deductible. You will also be responsible for any amount exceeding the out-of-Network reimbursement fee(s) which are calculated based upon Medicare allowable amounts. The amount you pay in excess of the out-of-Network reimbursement rate will not apply to your out-of-pocket maximum. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the remainder of the year. Please be sure to take this into consideration if you are considering using an out-of-Network Provider.

Prescription Drug Coverage

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

How the Medical Benefit Options Work

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

Under the PPO 1500, PPO 2500, and Out-of-Area Options, you are required to satisfy an annual Deductible before the plan begins paying a percentage of the eligible, Medically Necessary expenses

(with the exception of preventive care). All of the Medical Benefit Options allow you to use any qualified licensed Physician. When you use a Network Provider, you are not responsible for the difference between the billed fee and the Network rate. See "Special Provisions," below for information regarding Physicians, hospitals, and other medical service Providers that have agreed to charge discounted fees for medical services.

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

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

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

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

Key Features of the Medical Benefit Options

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

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

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

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

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

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

- Under the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options, all amounts applied to the Deductible, Copayments, and Coinsurance amounts, apply to the annual out-of-pocket maximum.

Pre-authorization: Call your Network/Claim Administrator in the following situations:

- To pre-authorize a surgery or hospitalization.
- If you are using out-of-Network services, you must call your Network and/or claims administrator to pre-authorize any surgery or hospitalization.
- If you need Emergency care, you should contact your Network and/or claims administrator within 48 hours after you receive initial care to ensure that your claim is processed at the in-Network benefit level as soon as possible.

- **Injury by others:** If someone else injures you and this Plan pays a benefit, the Company will recover payment from the third party. (This practice is known as *Subrogation*, which is described in more detail under "Claims" in the *Plan Administration* section.)

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

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

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

Medical Benefit Options Comparison

The following tables provide a summary of features under the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options. Benefits are available for Eligible Expenses that are Medically Necessary and within the Usual and Prevailing Fee Limits for the Out-of-Area Option.

The tables show the amount or percentage you pay for Eligible Expenses, and you pay any amounts not covered by the options. If you are covered under the PPO 750, PPO 1500, PPO 2500 or Out-of-Area Options and you use hospital-based services or services that require Coinsurance, you must satisfy the individual or family annual Deductible before the option pays benefits for Eligible Expenses.

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

- The out-of-pocket maximum under the medical options applies to coinsurance amounts you pay (i.e., for hospital services, including Inpatient and Outpatient care and surgery) as well as flat dollar co-payments. The out-of-pocket maximum also includes Deductibles, but it does not include amounts not covered, or amounts exceeding the Usual and Prevailing Fee Limits for out-of-Network services.
- Visit your Network and/or claims administrator website or call to determine if your Physician is a Network Provider.

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

PPO 750 Option

Facts about the PPO 750 Option

- Coinsurance applies once you have satisfied the Deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.
- $50 per person retail prescription drug deductible per year.
- Certain Preventive medications bypass the Deductible; however copays/Coinsurance still applies.

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

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

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

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

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

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

PPO 1500 Option

Facts about the PPO 1500 Option

- Coinsurance applies once you have satisfied the Deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.
- If more than one person is covered, the family Deductible must be satisfied before coinsurance applies.
- If more than one person is covered, the family OOP maximum must be met before the individuals covered in the family plan will receive 100% coverage. However, an individual covered in a family plan will receive 100% coverage after that individual reaches $6,650, unless such individual changes benefit options mid-year pursuant to a HIPAA special enrollment right.
- Certain Preventive medications bypass the Deductible; however copays/coinsurance still applies.

Plan Features	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS		
Individual Annual Deductible (If more than one person is covered, the individual Deductible will not apply)	$1,500	$3,000
Family Annual Deductible (If more than one person is covered under this option, the Family Deductible applies to all family members.)	$3,000 True Family Deductible	$6,000 True Family Deductible
Individual Annual Out-of-Pocket Maximum (If more than one person is covered, the individual Out-of-Pocket maximum will not apply)	$4,500	$9,000
Family Annual Out-of-Pocket Maximum (If more than one person is covered under this option, the Family Out-of-Pocket Maximum applies to all members of the family.)	$12,900	$25,800
PREVENTATIVE CARE – All services must be Medically Necessary		
Annual Routine Physical Exam	$0	Not Covered
Adult Immunizations	$0	Not Covered
Pap Test	$0	40% coinsurance if Medically Necessary: routine pap tests are not covered OON
Screening Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by Physician. Age 50 and beyond-once every year)	$0	Not Covered
PSA Screening and Colorectal Screening (According to age guidelines-routine coverage begins at age 50)	$0	Not Covered
Well Child Office Visits and Immunizations (Birth to age 18, initial	$0	Not Covered

Plan Features	In-Network	Out-of-Network
hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)		

Plan Features	In-Network	Out-of-Network
MEDICAL SERVICES – All services must be Medically Necessary		
Primary Care Physician's Office Visit	20% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	40% coinsurance
TeleHealth/MDLive	$44	$0
Gynecological Care Visit	20% coinsurance	40% coinsurance if Medically Necessary preventive care is not covered OON
Diagnostic Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by Physician. Age 50 and beyond – once every year)	20% coinsurance	40% coinsurance
Prenatal Care	$0	40% coinsurance
Pregnancy – Delivery by Obstetrician	20% coinsurance	40% coinsurance
Second Surgical Opinion	20% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	40% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-Network and out-of-Network combined per covered family member)	40% coinsurance (max of 20 visits per year in-Network and out-of-Network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	Not covered
Allergy Testing, Shots or Serum	20% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	40% coinsurance
OUTPATIENT SERVICES – All services must be Medically Necessary		
Outpatient Surgery in Physician's Office	20% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility (Including anesthesia and Medically Necessary assistant surgeon)	20% coinsurance	40% coinsurance

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

Plan Features	In-Network	Out-of-Network
Tubal Ligation	$0	40% coinsurance
Infertility Treatment (Including in-vitro fertilization)	Not Covered	Not Covered
Radiation Therapy	20% coinsurance	40% coinsurance
Chemotherapy	20% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	40% coinsurance
Hearing Aids	$3500 allowable per hearing aid. Replacement allowed every 36 months. 20% coinsurance	$3500 allowable per hearing aid. Replacement allowed every 36 months. 40% coinsurance
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Inpatient Mental Health Care	20% coinsurance	40% coinsurance
Alternative Mental Health Center – Residential Treatment	20% coinsurance	40% coinsurance
Alternative Mental Health Care Center – Intensive Outpatient and Partial Hospitalization	20% coinsurance	40% coinsurance
Outpatient Mental Health Care Visit	20% coinsurance	40% coinsurance
Marriage Counseling	Not Covered	Not Covered
Detoxification	20% coinsurance	40% coinsurance
Chemical Dependency Inpatient Rehabilitation	20% coinsurance	40% coinsurance
Chemical Dependency Outpatient Rehabilitation	20% coinsurance	40% coinsurance
PRESCRIPTION MEDICATIONS		
Pharmacy Deductible (Retail and Mail Order)	Prescriptions are subject to the Deductible; however, certain preventive prescriptions bypass the Deductible – contact Express Scripts for more information	Prescriptions are subject to the Deductible; however, certain preventive prescriptions bypass the Deductible – contact Express Scripts for more information

Plan Features	In-Network	Out-of-Network
Retail Refill Allowance (RRA)	Applies to maintenance Prescription drugs. The first three times that you purchase a maintenance drug at a participating retail pharmacy, you may pay your retail copay or co-insurance. After the third purchase at retail, you will pay 100% of the drug's cost and the amount you pay will not count towards your out-of-pocket maximum. You must move your maintenance medications to Express Scripts' mail order pharmacy to receive coverage after your third fill.	
Retail Pharmacy (Up to a 30 day supply)	Generic: 20% coinsurance ($10 Min/$50 Max) Preferred Brand: 30% coinsurance ($35 Min/$100 Max) Non-Preferred Brand: 50% coinsurance ($50 Min/$125 Max) An additional $5 copay will apply if using a non-preferred Network pharmacy	Drug reimbursement at an OON pharmacy is based on Network pricing
Mail Service Pharmacy (Up to a 90 day supply)	Generic: 20% coinsurance ($25 Min/$125 Max) Preferred Brand: 30% coinsurance ($75 Min/$200 Max) Non-Preferred Brand: 50% coinsurance ($125 Min/$275 Max)	Not Covered
Prescription-filled Contraceptives	Oral Contraceptives, transdermal, and intravaginal contraceptives covered at 100% at mail order only. This includes both generic and brand name contraceptives. You will be responsible for the cost difference between generic and brand name medications if you select a brand name contraceptive that has a generic equivalent, unless your health	Not Covered

Plan Features	In-Network	Out-of-Network
	care Provider determines that a generic contraceptive would be medically inappropriate. The cost difference you pay does not count toward your out-of-pocket maximum.	
Prescription Drug Information	If you select a brand name drug when a generic equivalent is available, you will pay the generic 20% coinsurance plus the cost difference between brand and generic prices. Maximums do not apply in this situation and the cost difference you pay does not count towards your out-of-pocket maximum.	
Over-the-counter Medication	Not Covered unless required by the Affordable Care Act and the participant has a Prescription	Not Covered unless required by the Affordable Care Act and the participant has a prescription
OTHER INFORMATION		
Pre-determination of Benefits (See Prior Authorization)	Recommended before hospitalization and surgery for all plans, for Network and out-of-Network. Call BCBS for more information.	Recommended before hospitalization and surgery for all plans, for Network and out-of-Network. Call BCBS for more information.
Hospital Preauthorization (See Prior Authorization)	Required before hospitalization and recommended before Outpatient surgery. Call BCBS for more information.	Recommended before hospitalization and surgery for all plans, for Network and out-of-Network. Call BCBS for more information.

PPO 2500 Option

Facts about the PPO 2500 Option

- Coinsurance applies once you have satisfied the Deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.
- f more than one person is covered, the family Deductible must be satisfied before coinsurance applies.
- If more than one person is covered, the family OOP maximum must be met before the individuals covered in the family plan will receive 100% coverage. However, an individual covered in a family plan will receive 100% coverage after that individual reaches $6,650, unless such individual changes benefit options mid-year pursuant to a HIPAA special enrollment right.
- Certain Preventive medications bypass the Deductible; however copays/coinsurance still applies.

Plan Features	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS		
Individual Annual Deductible *(If more than one person is covered, the individual Deductible will not apply)*	$2,500	$5,000
Family Annual Deductible *(If more than one person is covered, the individual Deductible will not apply)*	$5,000 True Family Deductible	$10,000 True Family Deductible
Individual Annual Out-of-Pocket Maximum (If more than one person is covered, the individual Out-of-Pocket maximum will not apply)	$6,450	$12,900
Family Annual Out-of-Pocket Maximum (If more than one person is covered under this option, the Family Out-of-Pocket Maximum applies to all members of the family.)	$12,900	$25,800
PREVENTATIVE CARE – All services must be Medically Necessary		
Annual Routine Physical Exam	$0	Not Covered
Adult Immunizations	$0	Not Covered
Pap Test	$0	40% coinsurance if Medically Necessary: routine pap tests are not covered OON

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

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

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

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

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

Out of Area Coverage Option

Plan Features	In-Network and Out-of-Network
DEDUCTIBLES/MAXIMUMS	
Individual Annual Deductible (If more than one person is covered, the individual Deductible will not apply)	$750
Family Annual Deductible (If more than one person is covered, the individual Deductible will not apply)	$1,500
Individual/Family Annual Out-of-Pocket Maximum	$4,950/$9,900
PREVENTIVE CARE	
Annual Routine Physical Exam, Including Well Woman Exam	Covered at 100%
Adult Immunizations	Covered at 100%
Pap Test	Covered at 100%
Screening Mammogram as described in the USPSTF A or B recommendations	Covered at 100%
PSA Screening and Colorectal Screening as described in the USPSTF A or B recommendations	Covered at 100%
Well Child Office Visits and Immunizations (Preventive Care based on ***USPSTF Grade A & B recommendations and CDC guidelines)***	Covered at 100%
MEDICAL SERVICES	
Primary Care Physician's Office Visit	20% coinsurance
Specialist Office Visit	20% coinsurance
Gynecological Care Visit	20% coinsurance
Diagnostic Mammogram	20% coinsurance (if Medically Necessary); routine Mammograms are covered according to specific guidelines – refer to Mammograms in "Covered Expenses"
Pregnancy – Physician Services	20% coinsurance
PSA and Colorectal Diagnostic Exam	20% coinsurance
Second Surgical Opinion	20% coinsurance
Urgent Care Center Visit	20% coinsurance
Chiropractic Care Visit	20% coinsurance

Plan Features	In-Network and Out-of-Network
	(max of 20 visits per year in-Network and out-of-Network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance
Acupuncture: Medically Necessary Treatment (Performed by a Certified Acupuncturist) only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury	20% coinsurance
Allergy Care	20% coinsurance
Diagnostic X-ray and Lab	20% coinsurance
OUTPATIENT SERVICES	
Outpatient Surgery in Physician's Office	20% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance
Pre-admission Testing	20% coinsurance
HOSPITAL SERVICES	
Inpatient Room and Board (Including intensive care unit or special care unit)	20% coinsurance
Ancillary Services (Including x-rays, pathology, operating room, and supplies)	20% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via my.envoyair.com within 30 days or these charges will not be covered.)	20% coinsurance
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance
Blood Transfusion	20% coinsurance
Organ Transplant	20% coinsurance
Emergency Ambulance	20% coinsurance

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

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

Special Provisions

Missing Persons/Uncashed Checks: If the Network/Claims Administrator cannot locate a Plan participant, after making a reasonably diligent effort, including by giving written notice addressed to the Plan participant's last known address as shown by the records of the Network/Claims Administrator, the amount payable to the Plan participant is forfeited and shall be considered the property of the Plan. Plan Participants may contact the Network/Claims Administrator to request that forfeited benefits be reinstated. Similarly, if a Participant fails to cash a check for benefits under the Plan within the time period noted on the check, or, if no time period indicated, within one year of issuance, the amount payable to the Participant is forfeited. Plan Participants may contact the Network/claims Administrator to request reissuance.

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

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

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

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

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

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

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

If you have elected medical coverage under the PPO 1500 or PPO 2500 Options, and you enroll at least one other family member with you in this coverage, the Individual Annual Deductible will not

apply for any members of your family. All eligible expenses incurred and paid by family members under the PPO 1500 and PPO 2500 Options will apply towards satisfaction of the Family Deductible.

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

If you have elected medical coverage under the PPO 1500 or PPO 2500 Options, and you enroll at least one other family member with you in this coverage, the Individual Annual Out-of-Pocket will not apply to you and any members of your family enrolled in such coverage. In general, an individual will not be required to pay more than the Affordable Care Act's out of pocket maximum for self-only coverage in 2018 ($7,350) unless an individual changes benefit options mid-year pursuant to a HIPAA special enrollment right. All eligible expenses incurred and paid by family members under the PPO 1500 and PPO 2500 Options will apply towards satisfaction of the Family Out-of-Pocket Maximum.

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

If you have elected medical coverage under the PPO 1500 or PPO 2500 Options, and you enroll at least one other family member with you in this coverage, the Individual Annual Out-of-Pocket Maximum will not apply to members of your family enrolled in such coverage. Once the Individual Annual Out-of-Pocket Maximum has been satisfied, the Plan will pay covered expenses at 100% for such Individual for the remainder of the calendar year. In general, an individual will not be required to pay more than the Affordable Care Act's out of pocket maximum for self-only coverage ($7,350 for 2018) unless an individual changes benefit options mid-year pursuant to a HIPAA special enrollment right. All eligible expenses incurred and paid by family members under the PPO 1500 and PPO 2500 Options will apply towards satisfaction of the Family Out-of-Pocket Maximum.

Medical Discount Program: The Medical Benefit Options offer a voluntary Preferred Provider Organization (PPO), which is a Network of Physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services. The Medical Discount Program helps save you and the Company money when you or a covered dependent needs medical care and chooses a participating Provider.

This discount is automatic when you present your Medical Benefit Option ID card to a PPO Provider, even if you are enrolled in the Out-of-Area Option. PPO Network Providers who contract with your Network and/or claims administrator agree to provide services and supplies at discounted rates. When you use a Network Provider, you are not responsible for the difference between the amount charged by the Network Provider and the amount allowed by their contractual agreement with your Network and/or claims administrator. Please keep in mind that some Providers charge more than others for the same services. For this reason, using a participating Provider may not always be the least expensive alternative. However, you will always receive a discount off that Provider's normal fees.

Contact your Network and/or claims administrator to learn more details about this Medical Discount Program feature or go to your Network and/or claims administrator's website for a list of PPO

Providers in your area. Because these Network Providers may change, you should confirm that your Physician is part of the Network whenever you make an appointment.

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

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

Out-of-Network Services

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

Primary Care Physicians

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

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

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

Continuing care: In the event you are newly enrolled in a Medical Benefit Option, and you or a covered family member has a serious illness, or you or your spouse are in the 20th (or later) week of pregnancy, you may ask your Network and/or claims administrator to evaluate your need for

continuing care. You may be eligible to continue with your current care Provider at the Network benefit level, even if that Provider is not part of the Network. Contact your Network and/or claims administrator for more information.

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

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

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

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

Filing claims: In most cases, when you use Network Providers, they file your claims for you.

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

If you move out of your Network service area, you will only be eligible for the Out-of-Area Option. You must contact the Benefits Service Center to process a relocation Life Event within 30 days of the event. This allows you to update your records and make a new benefits coverage selection, if applicable. If you do not notify the Benefits Service Center of your election, you will be enrolled in a plan offered in your new location. (See the *General Enrollment* section.)

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

When you use Network Providers, you receive a higher level of benefits, called in-Network benefits.

TeleHealth: If you have a minor medical illness or injury, general medical services are available. Simply download the MDLive app, enter the information from your medical ID card and a form of payment.

CopaymentPrescription

Prior Authorization and Pre-Determination for Certain Medical Services

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

- The recommended service or treatment is covered by your selected Medical Benefit Option.
- Your Physician's proposed charges fall within the Plan's out-of-Network reimbursement rates or if covered under the Out-of-Area option, if your Physician's proposed charges fall within the Usual and Prevailing Fee Limits. If you are covered by the PPO 750, PPO 1500 or PPO 2500 Option and you are using a PPO Provider, the Provider's fees are not subject to the Usual and Prevailing Fee Limits. However, you may want to contact your Network/Claims Administrator to determine if the proposed services are covered under your selected Medical Benefit Option or to obtain cost information for different in-Network Providers.

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

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

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

Prior Authorization Recommended	
Assistant surgeon	A fee for an assistant surgeon is only covered when there is a demonstrated Medical Necessity. To determine if there is a Medical Necessity, you should contact your Network/Claims Administrator.
Multiple Surgical Procedures	If you are having Multiple Surgical Procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee

	for the primary surgeon. You can contact your Network/Claims Administrator to find out how the Plan reimburses the cost for any additional procedures.
Wellness Preventive Services	Contact your Network/Claims Administrator to determine if your option covers a specific preventive service for a particular medical condition.

Pre-Authorization

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

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

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

- Diagnosis and diagnosis code
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and telephone number
- Name and telephone number of the hospital or clinic where surgery is scheduled.

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

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

Your Network/Claim Administrator will tell you:

- Whether the proposed treatment is considered Medically Necessary and appropriate for your condition
- The number of approved days of hospitalization

- In some cases, your Network/Claim Administrator may refer you for a consultation before surgery or hospitalization will be authorized. To avoid any delays in surgery or hospitalization, notify your Network/Claim Administrator as far in advance as possible

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

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

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

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

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

Covered Expenses

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

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

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

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

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

- The nearest hospital qualified to provide necessary treatment in the event of an Emergency
- The nearest hospital or Convalescent or Skilled Nursing Facility for Inpatient care

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

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

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

Assistant surgeon: The Medical Benefit Options only cover assistant surgeon's fees when the procedure makes it Medically Necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered Medically Necessary, contact your Network/Claims.

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

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

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

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

To be eligible, the confinement in a Convalescent or Skilled Nursing Facility must begin within 15 days after release from the hospital and be recommended by your Physician for the condition which caused the hospitalization.

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

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

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

Other cosmetic surgery is not covered because it is not Medically Necessary.

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

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

Detoxification: Detoxification is covered when alcohol and drug addiction problems are sufficiently severe to require immediate Inpatient medical and nursing care services. Contact your Network/Claim Administrator for authorization.

Dietician services: Coverage includes services recommended by your Network Provider and provided by a licensed Network dietician. Dietician services are not covered under the Out-of-Area Options.

Durable medical equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the

purchase of such items instead of rental. Replacement of DME is covered only when Medically Necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME resulting from normal wear and tear is not covered.

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

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

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

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

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

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

You should call your Network/Claim Administrator to be sure Home Health Care is considered Medically Necessary.

Hospice care: Eligible Expenses Medically Necessary for the care and treatment of a terminally ill covered person. Expenses in connection with Hospice Care include both facility and Outpatient care. Hospice care is covered when approved by your Network/Claim Administrator.

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

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

Mammograms: Medically Necessary diagnostic Mammograms, regardless of age.

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

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

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

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

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

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

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

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

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

To enroll your newborn baby in your health benefits, you must process a Life Event change within 30 days of the birth. If you miss the 30-day deadline you will not be able to add your baby to your coverage until the next annual enrollment period, even if you already have other children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby.

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

Nursing care: Coverage includes Medically Necessary private duty care by a licensed Nurse, if it is of a type or nature not normally furnished by hospital floor Nurses.

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

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

Physical or occupational therapy: Medically Necessary Restorative and Rehabilitative Care by a licensed physical or occupational therapist when ordered by a Physician. Please note that these

services are covered in-Network. There is no coverage available if you receive these services from an out-of-Network Provider under the PPO 750, PPO 1500 and PPO 2500 medical options.

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

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

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

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Prescription prenatal vitamin supplements are covered. Federal law prohibits the Plan from limiting your length of stay to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours. However, federal law does not require you to stay any certain length of time. If, after consulting with your Physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

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

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

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

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

- Medications administered and entirely consumed in connection with care rendered in a Physician's office are covered as part of the office visit unless the medication is a specialty medication only covered under the Prescription Drug benefit. Contact your Network/Claims administrator or Express Scripts to determine if the medication is covered under your medical option.
- Medications which are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, Convalescent hospital, or similar institution which operates an on-premises pharmacy are covered as part of the facility's Ancillary Charges.

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

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

Preventive care will not be covered out-of-Network under any of the Medical Benefit Options, except the Out-of-Area Option.

Prostheses: Prostheses (such as a leg, foot, arm, hand, or breast) necessary because of illness, injury, or surgery. Replacement of prosthesis is only covered when Medically Necessary because of a change in the patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.

Radiology (x-ray) and laboratory expenses: Examination and treatment by x-ray, radium, or other radioactive substances, imaging/scanning (MRI, PET, CAT, and ultrasound), diagnostic laboratory tests, and routine mammography screenings for women (see Mammograms for guidelines). Please note that under the PPO 750 Option, your Network coverage depends on whether the care is received in a hospital-based setting or a Physician's office or independent non-hospital laboratory facility. If you are covered under the PPO 750 Option, and you receive radiology or laboratory services in a Network Physician's office, a Network non-hospital imaging center, or a Network non-hospital

laboratory, the Plan will cover these expenses at 100% if Medically Necessary. Receiving radiology and/or laboratory services at a hospital will most likely cost you the most, as these services will be subject to the Deductible and coinsurance. Check with the Provider and ask if they bill as Outpatient hospital facility or as a free-standing non-hospital facility. There are some Providers who may appear as an independent facility but are actually owned by a hospital and bill as if the service was performed in a hospital.

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

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

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

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

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

Out of Network Services are not covered under the plan.

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

TeleHealth: Telehealth services provided by MDLive for minor medical illness or injury, or general medical services.

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

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

Transplants: Expenses for transplants or replacement of tissue or organs if they are Medically Necessary and not Experimental, Investigational, or Unproven Services. Benefits are payable for natural or artificial replacement materials or devices.

Donor and recipient coverage is as follows:

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

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

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

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

- Artery or vein
- Bone
- Bone Marrow or stem cell
- Cornea
- Heart
- Heart and Lung
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataract surgery
- Intestine
- Kidney
- Kidney and Pancreas
- Liver
- Liver and Kidney
- Liver and Intestine
- Pancreas
- Pancreatic islet cell (allogeneic or autologous)

- Prosthetic bypass or replacement vessels
- Skin

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

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

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

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

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

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

Mental Health and Chemical Dependency Benefits

Mental Health Care

Covered expenses include Medically Necessary Inpatient care (in a psychiatric hospital, acute care hospital, or an alternative mental health care center) and Outpatient care for a mental health disorder.

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

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

Alternative mental health care center – intensive Outpatient and partial hospitalization: This type of care is covered when Medically Necessary. Contact your Network claims administrator for more information.

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

Chemical Dependency Care

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

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

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

Prescription Drug Benefits

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

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

Retail Drug Coverage

As a participant in one of the Medical Benefit Options under the Plan, you may have your prescriptions filled at any pharmacy. However, if you present your Express Scripts ID card at a Network pharmacy, you will have access to negotiated discount prices. Express Scripts' broad retail pharmacy Network includes more than 65,000 pharmacies. When you fill prescriptions, you are encouraged to use a preferred pharmacy. A preferred pharmacy includes those within the Express Advantage Network, a subset of your broader Network, featuring major chain and independent pharmacies, grocery stores, and mass merchants. Non-preferred pharmacies include those retail pharmacies within your broader Network but outside of the Express Advantage Network. Filling your prescriptions at a non-preferred pharmacy (e.g., Walgreens or CVS) will result in an additional $5 Copayment, on top of your copay/coinsurance referenced in the table below. To request a list of participating pharmacy chains in the broader Network as well as the Express Advantage Network, call Express Scripts at 1-866-544-2994 or visit the Express Scripts website.

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

A "formulary" is a preferred list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent committee of Physicians and pharmacies brought together by Express Scripts updates this list regularly based on continuous

evaluation of medications. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist.

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

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

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

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

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Generic Drug	You pay 20%, with a minimum of $10 and a maximum of $50 per Prescription (an additional $5 copay will apply if using a non-preferred Network pharmacy)	You pay 20% for a 90-day supply, with a minimum of $25 and a maximum of $125 per prescription
Formulary Brand Drug	You pay 30%, with a minimum of $35 and a maximum of $100 per Prescription (an additional $5 copay will apply if using a non-preferred Network pharmacy)	You pay 30% for a 90-day supply, with a minimum of $75 and a maximum of $200 per prescription
Non-Formulary Brand Drug	You pay 50%, with a minimum of $50 and a maximum of $125 per Prescription (an additional $5 copay will apply if using a non-preferred Network pharmacy)	You pay 50% for a 90-day supply, with a minimum of $125 and a maximum of $275 per prescription

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

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

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

Retail Refill Allowance

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

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

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

Filling Prescriptions

Follow these steps to fill prescriptions at a Network pharmacy:

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

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

If you have questions concerning this program, contact Express Scripts at the phone number on your Express Scripts ID card.

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

Claim Filing Deadline

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

Prior Authorization

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

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

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

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

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

Specialty Pharmacy Services

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

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

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

- Anemia/Neutropenia
- Growth Hormone

- Hemophilia
- Hepatitis C
- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs
- Osteoporosis
- Rheumatoid Arthritis and Other Autoimmune Conditions
- Pulmonary / Pulmonary Arterial Hypertension
- Other Various Indications

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

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

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

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

Mail Service Prescription Drug Option

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

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

Generic Drugs

Many drugs are available in generic form. Your Prescription will be substituted with a generic when available and your Physician considers it appropriate. A-rated generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand

equivalents. By using A-rated generic drugs, you save money for yourself and the Plan. If a brand name drug is not specified, your Prescription may be filled with the generic. However, if you elect to fill a Prescription with a brand name drug and a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between the generic and brand prices**,** unless the drug is required for preventive care and your health care Provider determines that a generic would be medically inappropriate.

Ordering Mail Service Prescriptions

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

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

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

Internet Refill Option

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

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

Other Refill Options

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

- Call at 1-866-544-2994 to request a refill. They will need your Express Scripts ID number, current mailing address, and Express Scripts Health Rx Services Prescription number

- If you prefer to order by mail, complete a mail service order envelope and attach your Express Scripts refill Prescription label to the form or write the Prescription refill number on the envelope. Include your payment with your order.

Maximum Medical Benefits

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

Reimbursement of Copayments/Coinsurance

Your mail order Copayment/coinsurance for eligible Prescription drugs counts towards your out-of-pocket maximum.
If you elected to participate in the Health Care Flexible Spending Account or the Health Care Savings Account (for the PPO 1500 and PPO 2500 options only) you may submit your Copayment/coinsurance expenses for reimbursement. (See the *Health Care FSA* section for details.)

Excluded Expenses

The following items are excluded from coverage, under all Medical Benefit Options offered under the Plan, unless otherwise stated.

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

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

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

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

Care not Medically Necessary: All services and supplies considered not Medically Necessary.

Cosmetic treatment:

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

Counseling: All forms of marriage and family counseling

Custodial care and Custodial Care items: Custodial care and items such as incontinence briefs, liners, diapers, and other items when used for custodial purposes, unless provided during an *Inpatient* confinement in a hospital or Convalescent or Skilled Nursing Facility.

Developmental therapy for children: Charges for all types of developmental therapy.

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

Drugs:

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

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

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

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

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

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

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

Foot care: Diagnosis and treatment of weak, strained, or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses, or toenails. Bunion removal and foot orthotics are covered for medical conditions excluding flat feet, weak feet or foot strain. Routine foot care is not covered. (This exclusion does not apply to the removal of nail roots.)

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

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

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

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

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

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

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

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

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

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

Nursing care:

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

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

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

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

Sleep disorders: Treatment of sleep disorders, unless it is considered Medically Necessary.

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

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

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

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

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

Usual and Prevailing: Any portion of fees for Physicians, hospitals, and other Providers that exceeds the *Usual and Prevailing Fee Limits*. (Applies to out-of-Network Providers.)

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

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

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

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

Contact your Network/Claims Administrator to determine if your option covers a specific preventive service for a particular medical condition.