

EXHIBIT 10

Summary Plan Description and Benefit Programs



INTRODUCTION

**Ryder System, Inc.
Summary Plan Description**

Full-Time Employees

2018

INTRODUCTION

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Your benefits make up a significant part of your total compensation. Your pay is only part of your total compensation package. Along with your paycheck, the programs below provide you the opportunity to take advantage of a benefit package that most effectively meets your personal and family needs:

- Medical Coverage
- Prescription Coverage
- Dental Coverage
- Vision Insurance Plan
- Eye Wear Discounts
- Health and Dependent Care Flexible Spending Accounts
- Disability Coverage
 - Basic and Additional Short-Term Disability
 - Basic and Additional Long-Term Disability
- Life Insurance Coverage
 - Basic Life
 - Additional Life
 - Spouse Life
 - Child(ren) Life
 - Accidental Death and Dismemberment (AD&D) Insurance
 - Seat Belt/Safety Net Benefit
 - Motorcycle Helmet Benefit
 - Business Travel Accident Insurance
- Hyatt Legal Plan
- 401(k) Savings Plan
- Other Benefits
 - Employee Assistance Program
 - Health Advocate
 - Adoption Assistance
 - Employee Discount Program
 - Power Financial Credit Union
 - Direct Deposit and Pay Cards
- Retirement Plan
- *RyderShares*

INTRODUCTION**About this Book**

This book is your Summary Plan Description (SPD) and Benefit Programs as of January 1, 2018 and contains a summary of all of the programs provided to you by Ryder System, Inc. On the following pages, you will find the most important provisions of the benefit programs offered to you as a Ryder employee.

Important Note: For some of the health and welfare plans referenced in this booklet, this booklet in combination with certain contracts and other related documents, serves as the official plan document. However, for other plans, such as the Retirement Plan and 401(k) Plan, there is a separate, stand-alone official plan document. To the extent there is any conflict between the official documents of any plan summarized in this booklet and the descriptions contain herein, the official documents shall govern in all cases. Additionally, certain of the plans described in this booklet are covered by the Employee Retirement Income Security Act of 1974 (ERISA). Provisions contained in this booklet that are mandated by ERISA shall apply only to those plans that are in fact covered by ERISA.

Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

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The chart below provides an overview of benefit plans discussed in this book.

Benefit Plan	Who Pays for Coverage	Enrollment
Medical Prescription Dental	Ryder and you, with pre-tax dollars from your pay*.	Annually. You may change coverage during the year only if you have a Qualified Life Event.
Non-Tobacco User Credit**	Ryder reduces your medical contribution by \$50 per month.	Annually. If you used tobacco but successfully complete the Company-approved tobacco cessation program, you may qualify for this credit during the year.
Vision Insurance Plan	You, with pre-tax dollars from your pay.	Annually. You may change coverage during the year only if you have a Qualified Life Event. Participation is automatic if you are eligible to participate in a Ryder Medical Plan.
Eye Wear Discount Program	Ryder	
Health Care and Dependent Care Flexible Spending Accounts	You, with pre-tax dollars from your pay.	Annually. You may change coverage during the year only if you have a Qualified Life Event.
Basic Short-Term Disability Basic Long-Term Disability Basic Life Insurance Seat Belt/Safety Net Benefit Motorcycle Helmet Benefit Business Travel Accident	Ryder	Participation is automatic. You do not need to enroll.
Additional Short-Term Disability	You, with pre-tax dollars from your pay.	Annually. You may decrease or drop your coverage at any time.
Additional Long-Term Disability	You, with post-tax dollars from your pay.	Annually. You may drop or decrease your coverage at any time.
Additional Life Insurance Spouse Life Insurance Child(ren) Life Insurance Employee/Family Accidental Death & Dismemberment (AD&D)	You, with post-tax dollars from your pay.	You may drop or decrease your coverage at any time. You may add or increase coverage during annual enrollment or any time during the year if you experience a Qualified Life Event***.
Hyatt Legal Plan	You, with post-tax dollars from your pay.	Annually. You may make a change to your coverage only if you experience a Qualified Life Event. The coverage change must be consistent with the change in family status.
Retirement Plan 401(k) Savings Plan	Ryder You, with pre-tax or post-tax dollars from your pay. Ryder may provide Company contributions.	Plan is closed to new entrants. You may enroll after 6 months of employment. You can make changes at any time during the year.
Ryder Shares (Employee Stock Purchase Plan)	You, with post-tax dollars	Quarterly. Eligible after 90 days of employment.
Other Benefits : Employee Assistance Program (EAP) Health Advocate Adoption Assistance Employee Discount Program Power Financial Credit Union Direct Deposit and Pay Cards	Ryder	If eligible, refer to enrollment terms and conditions of each respective plan

*Please note you may not pay pre-tax dollars for non-qualified domestic partner coverage. Reference the Eligibility Section for unique tax rules on domestic partner coverage.

**Some employees covered under a collective bargaining agreement may have a different set amount or have a credit included in their premium rate.

***Subject to approval by the insurance carrier.

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

Important Note: If you and/or your dependents have Medicare or will become eligible for Medicare, a Federal law gives you more choices about your prescription drug coverage. Please see the Administrative Information section of this book for more information.

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You are automatically enrolled in the following Company paid basic benefits:

- Short-Term Disability
- Long-Term Disability
- Life Insurance
- Business Travel Accident Insurance
- Seat Belt/Safety Net Benefit
- Motorcycle Helmet Benefit
- Eye Wear Discount Program
- Adoption Assistance (only if enrolled in an eligible Medical Plan)
- Employee Assistance Program (EAP)
- Health Advocate (only if enrolled in an eligible Medical Plan)

Plans You Have the Option to Enroll In

As a newly hired or newly eligible employee, you have the option to enroll in the following benefits during your first 60 days of employment. You can go online at www.Ryder.BenefitsNow.com or call the BenefitsNow Service Center at 800-280-2999. You have the option to enroll in the following benefits:

- Medical Coverage
- Prescription Coverage
- Dental Coverage
- Vision Insurance Plan
- Health Care Flexible Spending Account
- Health Savings Account (if you enroll in the HSA Medical Plan)
- Dependent Care Flexible Spending Account
- Additional Short-Term Disability Coverage
- Additional Long-Term Disability Coverage
- Additional Life Insurance Coverage
- Spouse Life Insurance Coverage
- Child(ren) Life Insurance Coverage
- Employee Accidental Death and Dismemberment Insurance Coverage
- Family Accidental Death and Dismemberment Insurance Coverage
- Hyatt Legal Plan

Generally, most coverage is effective the first of the month following 60 days (not to exceed 90 days) of continuous full-time, active employment. If you do not elect to participate in the optional programs during your first 60 days of employment, you will generally not be provided an opportunity to elect coverage until the next benefits annual enrollment, generally held in the fall. Coverage elections made during the fall annual enrollment become effective January 1st of the following year.

As a newly hired or newly eligible employee, **you have the option to enroll** in the following benefit after 6 months of employment. You can go online at www.netbenefits.fidelity.com or call the Ryder Retirement Service Center at 800-373-7300:

- 401(k) Savings Plan

Refer to the 401(k) Savings Plan section of the book for specific information regarding eligibility under this plan. A 401(k) Savings Plan Enrollment Guide will be mailed to you under separate cover.

Eligibility

This section describes the Eligibility rules for you and your dependents under the Health & Welfare plans, the Dependent Eligibility Audit, Working Spouse Eligibility Rule, Coverage Categories, Ryder Couples and Other Ryder Family Members, Enrollment, When Coverage Begins, Qualified Life Event Changes, When Coverage Ends, Coverage for Active Employees after Age 65, and Retirees.

Employees

You are eligible to participate in **Medical, Prescription, Dental, Vision, Flexible Spending Accounts, Short-Term and Long-Term Disability, Life Insurance, AD&D, Hyatt Legal Plan and the 401(k) Savings Plan** if you are an active, regular full-time employee of Ryder System, Inc. or any of its subsidiaries or affiliates that have elected to offer these plans to employees.

An employee shall not include any individual (1) designated by Ryder as an independent contractor and not an employee at the time of any determination, (2) being paid by or through an employee leasing company or other third party agency, (3) designated by Ryder as a freelance worker and not as an employee at the time of any determination, (4) designated by Ryder as a part-time seasonal, occasional, limited duration or temporary employee during the period the individual is so paid or designated. Any such individual shall not be an employee eligible for benefits even if he or she is later retroactively classified as a common-law employee of Ryder during any part or all of such period.

If you work under the provisions of a collective bargaining agreement or are covered under a valid, current written customer contract, you are eligible to participate if your agreement specifically provides for benefits under these plans.

Notwithstanding the foregoing, Ryder may use any method of determining full-time employee status as may be permitted under Treas. Reg. § 54.4980H-3 and may establish any permitted administrative period. The determination method need not be the same for all Colleagues/Employees and may be changed at the Company's discretion and to the extent permitted by Treas. Reg. § 54.4980H-3. Notwithstanding the foregoing, the Company may elect to be subject to an assessable payment rather than offer coverage under the [Medical Plan] pursuant to this paragraph.

Dependent

You may enroll your dependents in **Medical, Prescription, Dental, Vision, Spouse Life or Child Life Insurance, Family AD&D and Hyatt Legal**. You will need to provide the names and Social Security numbers of your eligible dependents. This information is necessary to comply with the Medicare Coordination of Benefit provision. Additionally, for employees who have Spouse Life Insurance, your spouse or domestic partner's date of birth is required to be on file with the Ryder BenefitsNow Service Center. Date of birth is needed to correctly calculate Spouse Life insurance premiums based upon your spouse or domestic partner's age. Eligible dependents include:

- your legal spouse of the same or opposite sex. Common-law spouses are treated as domestic partners, subject to the requirements outlined below. Ex-spouses are not eligible, even if a divorce decree requires medical coverage.
- your domestic partner, of the same or opposite sex, if he or she has met all of the following criteria for the 12 months before the coverage effective date:
 - the individual is your sole domestic partner and intends to remain so indefinitely;
 - you or the individual are not married or legally separated from each other or anyone else;
 - the individual is not related by blood or adoption to a degree of closeness that would prohibit legal marriage in the state in which he or she resides;
 - the individual is at least eighteen (18) years of age and mentally competent to consent to a contract;
 - you and the individual are living together in the same residence and intend to do so indefinitely;
 - you and the individual are engaged in a committed relationship of mutual caring and support

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and are jointly responsible for each other's common welfare and living expenses;

- your natural or adopted children, those of your spouse/domestic partner and children for whom you have legal custody or guardianship, to age 26.
- your natural or adopted children, those of your spouse/domestic partner and children for whom you have legal custody or guardianship, age 26 AND older, if due to a physical or mental disability, they are unable to support and maintain themselves financially. Eligibility for disabled dependent coverage is solely determined by the Medical Plan carrier you elect. You may apply for coverage by notifying the Ryder BenefitsNow Service Center (1) when you are first eligible to enroll in coverage or (2) if you are already enrolled, you must request continued coverage before the dependent's coverage would otherwise end.

Dependent Eligibility Audit

The Company will conduct eligibility audits for every dependent added to Ryder's coverage to ensure that only dependents who meet Ryder's eligibility requirements are covered under Ryder's Medical, Dental and Prescription Plans. If you are enrolling a dependent into your Medical, Prescription and/or Dental coverage, you must immediately comply with the Dependent Eligibility Audit requirement or your dependents will be dropped from your insurance. Acceptable proof is limited to:

- birth certificates for children (must indicate birth parents' names);
- current federal tax return AND marriage certificate for spouses, (current federal tax return: pages 1 and 2 of your signed and submitted tax return form (tax return must indicate filing status such as, married filing jointly, married filing separately, all dependents' names and social security numbers);
- court documents; or
- Domestic Partner/Common Law Spouse affidavit.

If your dependents are dropped due to failure to comply with the Dependent Audit by the deadline, you may appeal directly to the Dependent Audit Department by contacting the Ryder BenefitsNow Service Center. Reinstatement of dependents' coverage may only be allowed at the next annual enrollment, unless there is a Qualified Life Event. Intentional misrepresentation of dependent eligibility will be subject to disciplinary action, up to and including termination of benefits and termination of employment.

Domestic Partner Medical, Prescription and Dental Benefits

Because federal tax law does not recognize the rights of a domestic partner with respect to employee benefits, the employee cannot benefit from the federal income tax exclusion for benefits provided for a domestic partner or that partner's children, unless the domestic partner and/or his or her children qualifies as a dependent under Internal Revenue Code section 152 (generally, if you can claim the individual as a Tax Exemption in Section 6 on your Form 1040 Federal Tax Return, then they would be considered " tax qualified") . Under IRS guidelines, the Employee is subject to tax on the fair market value of the coverage provided to the non-qualified domestic partner and his/her dependent children. As such, all domestic partners will be considered non-qualified tax dependents unless you submit federal tax documents to prove their tax-qualified status. This status is subject to review annually.

These benefits may be subject to federal, state and other applicable tax withholding and the additional employer cost to cover the dependents will be reported as imputed income on the employee's federal W-2 Form at the end of each year in which coverage is elected for a domestic partner or for a domestic partner's dependent children.

Working Spouse Eligibility Rules

If your working spouse or domestic partner has comprehensive group medical, prescription and/or dental coverage available to him or her through his or her employer, your spouse or domestic partner **is not eligible** for coverage under the Ryder System, Inc. group medical, prescription and dental plans, regardless of cost, provider networks, plan design (copays, deductibles, coinsurance) or exclusion of certain procedures. Comprehensive medical coverage includes coverage for physician services,

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outpatient and inpatient hospitalization and prescriptions. Comprehensive dental coverage includes coverage for preventive, basic restorative and major restorative services.

Need to Know:

Ryder expects all employees to comply with the Working Spouse Eligibility Rule and to take the appropriate enrollment actions regarding plan coverage for their spouse or domestic partner.

If your working spouse or domestic partner...	then your working spouse or domestic partner CAN be covered under Ryder's...
is <u>not</u> eligible for medical or dental coverage through his/her employer,	Medical, Prescription and Dental Plans.
is eligible for a Medical Plan, but is not eligible for a dental plan,	Dental Plan, but <u>not</u> under Ryder's Medical Plan.
is eligible for a comprehensive Medical Plan, but there is no prescription coverage,	Medical and Prescription Plans.

If your working spouse or domestic partner...	then your working spouse or domestic partner CANNOT be covered under Ryder's...
is eligible for comprehensive medical and prescription coverage through his/her employer,	Medical and Prescription Plans.
is eligible for a comprehensive Medical Plan, but has a restricted provider network,	Medical and Prescription Plans.
is eligible for a comprehensive Medical Plan with a higher deductible than Ryder's Medical Plan for physician services, hospitalization or surgery,	Medical and Prescription Plans.
is eligible for a comprehensive Medical Plan or dental plan, but their doctor or dentist is not in the plan's network,	Medical and Prescription or Dental Plans.
is eligible for comprehensive medical, prescription and dental coverage, but the cost of coverage is more expensive than the cost for Ryder's plans,	Medical, Prescription or Dental Plans.
is eligible for comprehensive dental coverage,	Dental Plan.
is eligible for comprehensive dental coverage, but does not offer orthodontia,	Dental Plan.

Note: The Ryder Vision Insurance Plan is not subject to the Working Spouse Rule. Employees can enroll working spouses, even if they are offered vision insurance through their employer.

Coverage Categories

The **Medical, Prescription, Dental and Vision** Plans have four coverage categories:

- Employee only – covers only the employee;
- Employee + Spouse – provides coverage for the employee and their eligible spouse or domestic partner;
- Employee + Child(ren) – provides coverage for the employee and one or more eligible child; and
- Family – provides coverage for the employee, their spouse or domestic partner and one or more eligible child(ren).

You do not have to choose the same coverage category for each plan. However, to be eligible for Prescription Plan coverage, either you or you and your dependents must be enrolled in the Medical Plan.

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Ryder Couples and Other Ryder Family Members

If both you and your spouse are Ryder employees, only one of you needs to enroll in the **Medical, Prescription, Dental or Vision Plans**. The other may be covered as a dependent. You may not be enrolled as an employee and as a dependent in the Medical, Prescription, Dental or Vision Plans. If you have children, only one of you may cover your children.

However, under the Additional Life Insurance and Accidental Death and Dismemberment (AD&D) plans, you may elect Additional Life and Accidental Death and Dismemberment (AD&D) coverage as both an employee and as a spouse. If you have children, the children may be covered under only one parent for Child(ren) Life and AD&D.

If any child qualifies as an eligible Ryder employee, he or she is not eligible to be covered as a dependent child under a Ryder parent's Child Life and Family AD&D plans.

Enrollment

You have the opportunity to enroll in your benefits online by logging into the benefits portal at www.Ryder.Benefitsnow.com. You will also receive an enrollment package shortly after you start working for the Company and/or you become eligible to enroll in the **Medical, Prescription, Dental, Vision Insurance, Flexible Spending Accounts, Additional Short-Term Disability (STD)*, Additional Long-Term Disability (LTD)**, Additional Life Insurance, Dependent Life Insurance, Accidental Death and Dismemberment (AD&D), and the Hyatt Legal Plan**. All enrollment opportunities have a deadline date.

- if you are a newly hired employee, you must elect to participate within 45 days after your date of hire;
- if you are a rehired employee within 24 months from your most recent termination date, you must elect to participate in plan coverage within 30 days of your date of rehire; or
- if you were rehired after 24 months from the date of termination, you must elect to participate in plan coverage within 45 days of your date of rehire.

*Additional STD is only available for Hourly employees. Salaried employees are automatically enrolled in the Salary Continuance Plan.

**You are automatically enrolled for Basic LTD coverage. Additional LTD is available for both Hourly and Salaried employees. Refer to the LTD section.

If you do not elect coverage by the deadline date, you will not be able to enroll in benefits until Annual Enrollment at the end of the year, or when you have a Qualified Life Event. Any coverage elected during Annual Enrollment will become effective on January 1 of the following year. Some plans are subject to approval by the insurance carrier if you decide to enroll after your initial enrollment date.

When Coverage Begins

New Hires

If you elect coverage when you first become eligible to enroll, your coverage begins on the first of the month following 60 days (not to exceed 90 days) of continuous, regular, active full-time employment. If you are on medical leave during the 60-day waiting period, you will be treated as being at work during your medical leave days for purposes of eligibility for all benefits. In any case, to be eligible for any benefits, you must have worked for at least one full day. If for any reason during this period, your service is interrupted by a personal or other leave of absence not due to your own medical condition, your 60-day waiting period will stop. When you return from leave you will be subject to a new 60-day waiting period before benefits are effective. If your absence is due to qualified military service (as defined by USERRA), upon your return to work, your waiting period will continue where it left off.

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If you were previously covered by a collective bargaining agreement and become eligible for the Ryder Benefits Program, your coverage will be effective on the day you change from union to non-union status, if you have been continuously employed by the Company for 60 days, as a regular full-time active employee. If you have not yet been continuously employed by the Company for 60 days, your days worked under the collective bargaining agreement will count toward the 60-day waiting period. In any case, to be eligible for any benefits, you must have worked for at least one full day.

Rehires

If you previously worked for Ryder System, Inc. or one of its subsidiaries or affiliates and are rehired, the date your coverage begins is determined by the length of time between your date of termination and date of rehire. If you are a rehired employee, coverage is effective the first of the month following the date of rehire if:

- you are rehired within 24 months of the date of termination; and
- you have previously met the 60-day waiting period;
- except, if you have not previously met the 60-day (not to exceed 90 day) waiting period, coverage begins on the first of the month following 60 days (not to exceed 90 days) of continuous full-time active employment from your most recent rehire date.
- If you are rehired within 30 days, your prior coverage is reinstated to the same coverage you had when you left the company as long as it does not cross plan years.

If you are rehired after 24 months from the date of termination, coverage is effective the first of the month following 60 days (not to exceed 90 days) of continuous, active full-time employment.

If you are on medical leave during any 60-day waiting period, you will be treated as being at work during your medical leave days for purposes of determining your benefits begin date. In any case, to be eligible for any benefits, you must have worked for at least one full day.

Part Time to Full Time Status Change

If you are currently a part time employee (not eligible for benefits), and you change to full time status, coverage for benefits is effective on the first day of the month following 60 days (not to exceed 90 days). You must enroll with 45 days of your status change.

If within 24 months of your status change and you were previously full time and met your eligibility waiting period, coverage will be effective the first of the month following your status change date. You must enroll within 30 days of your status change.

Absence on Effective Date of Coverage

If you are not actively at work full-time on the date your coverage is scheduled to begin, your coverage will be delayed until you return and are actively at work for one full day. This delay does not apply if your absence from work is due to your own medical leave, in which case you will be treated as being actively at work on the day your coverage begins. Once coverage is put in place, you will receive a COBRA Notice with the option of continuing coverage during your medical leave. You must pay for coverage in order to keep your benefits active during your medical leave. You are considered to be actively at work while on vacation or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday. If you changed your coverage option during Annual Enrollment and you are not actively at work on January 1 of the next calendar year, you will be covered under the prior year's coverage option until you return to work.

Absence on Effective Date for Life and Accidental Death & Dismemberment

If you are not actively at work full-time on the date your coverage is scheduled to begin, your coverage will be delayed until you have been actively at work for one full day.

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If you changed your coverage option during Annual Enrollment and you are not actively at work on the day your new coverage is scheduled to begin, you will be covered under the prior year's coverage option until you return to work.

You are considered to be actively at work while on vacation or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday. If you changed your coverage option during Annual Enrollment and you are not actively at work on January 1 of the next calendar year, you will be covered under the prior year's coverage option until you return to work.

If a dependent is confined at home, in a hospital or elsewhere because of a physical or mental condition on the date his or her coverage would become effective, the new coverage will begin as of the date when the dependent is no longer totally disabled.

Absence on Effective Date for Short-Term and Long-Term Disability

If you are not actively at work on a full-time basis on the date your STD and LTD coverage is scheduled to begin, your coverage will be delayed until you have been actively at work for one full day. You are considered to be actively at work when you are performing the duties of your job at your normal place of work. You are considered to be actively at work while on vacation or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday. If you changed your coverage option during Annual Enrollment and you are not actively at work on January 1 of the next calendar year, you will be covered under the prior year's coverage option until you return to work.

Personal Unpaid Leaves

If you are on a personal unpaid leave, your benefits will end on the last day of the month in which your personal unpaid leave took place. You may elect to continue your health insurance coverage through COBRA during this time. When you return to work, your benefits will become effective the first of the following month from the date you return to work.

Qualified Life Event Changes

You cannot change or enroll in coverage after your initial enrollment opportunity unless you experience a Qualified Life Event. You have 31 days from the date of the event to add or drop coverage, add or drop your dependents or change your dependent coverage category. You may **not** change from one plan option to another in the middle of any calendar year. Generally, the change requested must be consistent with the Qualified Life Event.

Below is a list of Qualified Life Events:

- marriage, divorce, or legal separation of the employee;
- birth, adoption or placement for adoption of a child;
- death of a spouse or other dependent;
- spouse's gain or loss of employment or dependent gains or loses coverage;
- employee's or spouse's change in employment status from full-time to part-time (or vice versa);
- employee or spouse taking an unpaid leave of absence;
- change of residence if it results in becoming ineligible for your current health coverage;
- dependents satisfying or ceasing to satisfy eligibility requirements (i.e., a dependent child who has reached the plan's maximum age requirement);
- changes in coverage required by a judgment, decree or order;
- eligible for Medicare;
- a significant change in health care coverage for employee and/or spouse that is attributable to spouse's employment (does not apply to the Health Flexible Spending Account Plan); cost changes for any Dependent Care Assistance does not apply if the cost change is made by a relative of the Employee or Spouse;
- other events approved by the plan administrator and are consistent with IRS statutes or regulations;

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- you and/or your dependent(s) lose other health coverage (but not due to failure to pay premiums on a timely basis, voluntary disenrollment, or termination for cause);
- the Company contributions to the other coverage have stopped; or
- the other coverage was COBRA and the maximum COBRA coverage period ends.

The loss of your selected network provider in any of the Medical, Dental or Vision Plans do not allow you to make changes in your plan or coverage election.

The date in which you and your domestic partner meet all of the Ryder domestic partner eligibility criteria is not considered a Qualified Life Event by the IRS. Therefore, a newly eligible domestic partner and/or his or her dependents can only be added to coverage during Annual Enrollment. Once a domestic partner or his or her dependents are otherwise eligible, other Qualified Life Events apply.

Coverage changes to the Hyatt Legal Plan must be consistent with the Qualified Life Event, but in no event can you cancel coverage during the year.

You may decrease or terminate coverage in Additional Long-Term Disability, Additional Life, Spouse Life, Child(ren) Life, Employee and Family Accidental Death & Dismemberment at any time during the year. However, requests to re-enroll or increase your Additional Long-Term Disability, Additional Life, or Spouse Life coverage during any subsequent Annual Enrollment may be subject to insurance carrier approval.

You may begin, end, decrease or increase your contribution in the Health Care or Dependent Care Spending Accounts as long as it is consistent with the Qualified Life Event.

Changes to the Non-Tobacco User Credit plan can only be made:

- during Annual Enrollment;
- after you successfully complete a Company-approved tobacco cessation program; or
- after you experience a Qualified Life Event where you remove your spouse/domestic partner from your coverage and, in doing so, you then qualify for the Credit, provided you are tobacco-free.

If a tobacco cessation program is successfully completed, you may elect the Non-Tobacco User Credit at that time, provided your enrolled spouse/domestic partner is also tobacco-free.

To make a change to your benefits, contact the Ryder BenefitsNow Service Center within 31 days of the Qualified Life Event. Changes become effective on the date of the Qualified Life Event.

When Coverage Ends

Your coverage under the **Medical, Prescription, Dental and Vision** generally ends on the last day of the month when:

- your employment with the Company is terminated;
- you change to an ineligible status;
- you cancel your coverage;
- you stop making contributions; or
- Ryder changes or no longer offers the program.

Your dependents' coverage under the **Medical, Prescription, Dental and Vision** generally ends on the last day of the month when:

- your coverage ends;
- your dependent, such as your spouse, domestic partner, child or spouse's or domestic partner's child, no longer meets the definition of a dependent; or
- you cancel dependent coverage.

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Your participation in the **Flexible Spending Accounts** generally ends the day:

- your employment with the Company is terminated;
- you change to an ineligible status;
- Ryder amends or terminates the plan; or
- you stop making contributions to your account(s);

The coverage of an employee who is otherwise ineligible under the Plan but was offered medical coverage solely on the basis of his or her “full-time employee” status under the Affordable Care Act (ACA) and not the Plan’s general eligibility rules, will terminate on the last day of the stability period for which the covered employee was determined to be a “full-time employee” under ACA during a preceding measurement period (as determined by Ryder in accordance with Treas. Reg. § 54.4980H-3).

If your employment with Ryder ends during the calendar year, your participation ends on the day you stop working, unless you choose to continue participation in the Health Care Account through COBRA continuation coverage. If you do not choose to continue participation through COBRA, only expenses up to the day you terminate are eligible for reimbursement. Continuation coverage is explained in greater detail in the Administrative Information section of this book. Continuation coverage is not available for the Dependent Care Account, but you may continue to submit claims incurred prior to your termination date until you use up the money in your account. The deadline for submitting Flexible Spending Account claims for the calendar year in which you terminate still applies.

Your **Short-Term and Long-Term Disability** coverage generally ends when:

- you leave the Company (the last day of active employment);
- you change to an ineligible status;
- you are temporarily laid off;
- you take a leave of absence, including a leave for military service;
- you are absent due to a general work stoppage, including a strike or lockout;
- you cancel your coverage;
- you stop making contributions for plans which require it;
- Ryder changes, or no longer offers the program; or
- the date the policy or plan is cancelled.

Your **Life Insurance and AD&D** coverage generally ends on the day:

- you leave the Company (the last of active employment);
- you change to an ineligible status;
- you cancel your coverage;
- you stop contributions for additional coverage (the last day of the month for which you made any required contributions);
- Ryder no longer offers the program; or
- the date the policy or plan is cancelled.

Your **Spouse and Child Life Insurance** coverage generally ends on the earliest of the date:

- your coverage ends;
- you stop contributions for dependent life insurance coverage (the last day of the month for which you made any required contributions);
- the dependent is no longer eligible for coverage; or
- the date the policy or plan is cancelled.

Your spouse or domestic partner is no longer eligible for coverage in the event you are divorced or when your domestic partner ceases to meet the criteria for coverage. Your children are no longer considered eligible dependents when they reach age 26, unless they have been approved by your Medical Plan benefits administrator to be disabled due to a mental or physical handicap.

ELIGIBILITY

You must contact the Ryder BenefitsNow Service Center to drop Spouse and/or Child Life and Family AD&D insurance coverage for ineligible dependents within 31 days of the date they became ineligible. Benefits under the Life and AD&D insurance plans are not payable to you if your dependents are deemed ineligible, regardless if you were paying the monthly premiums.

Your coverage under the health and welfare plans may be terminated or suspended if you provide any false information, misrepresentation, or misstatement of material fact when you enroll, or with respect to any request for benefits. Any such termination or suspension of coverage will be made in accordance with the Patient Protection and Affordable Care Act and the regulations and guidance issued thereunder.

Coverage for all plans may be reinstated, at the Company's discretion, one year after suspension of benefits because of false information, if the falsely obtained benefits are repaid. Such falsification may result in other disciplinary action, as outlined in your Ryder Employee Handbook.

If you are laid off due to lack of work, coverage will end on the last day of the month you were laid off. If your employment is continued due to a leave of absence, an injury or sickness, your coverage may continue, until the date your employment ends.

Coverage for Active Employees After Age 65

If you continue working after age 65, your coverage under the Medical and Prescription Plans may continue. If you or a dependent enroll for Medicare, the Ryder plan will be primary. Medicare benefits will be secondary.

Ryder has determined that the prescription drug coverage provided under the Prescription Plan is, on average, at least as good as the standard Medicare prescription drug coverage. This means that you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage. Please review the Notice of Creditable Coverage in the Administrative Section of this book, which provides important information about how the Prescription Plan coverage interacts with Medicare Part D coverage.

Retirees

Ryder offers retiree medical and prescription drug coverage for certain employees who met the grandfathering criteria as of December 31, 2013, as well as to employees in certain business locations. Eligibility is determined based on your organizational assignment at the time your employment ends with the Company. Note that if you are covered under a Union Medical Plan as an active employee, you are not eligible for retiree medical and prescription drug coverage.

Note: If you are currently working in an organizational assignment that provides for participation in the Ryder Retiree Medical and Prescription Plan, you may lose eligibility if (prior to your retirement) you transfer to an organizational assignment that does not provide for participation in the Ryder Retiree Medical and Prescription Plan. Eligibility for the Ryder Retiree Medical and Prescription Plan will be determined based on your organizational assignment at the time you leave the Company.

The retiree medical and prescription drug plan will only be available to active employees who reached age 52 and had at least 12 years of credited Ryder service as of December 31, 2013. Additionally, the determination of eligibility for retiree medical and prescription coverage is made at the time of your retirement. You are considered eligible to participate if you meet the following criteria:

- You are a full-time employee between the ages of 55 and 65 with 15 or more years of continuous service
- You are the Spouse/Domestic Partner and/or dependent child of any full-time employee who met the above criteria at the time of their retirement from Ryder.

ELIGIBILITY

To be eligible to participate in this program, your dependents must have been eligible for coverage while you were an active employee and be one of the following:

- Your legal Spouse/Domestic Partner under the age of 65 (see Working Spouse Eligibility Rule below)
- You or your Domestic Partner's child up to age 26
- You or your Domestic Partner's unmarried child of any age who is disabled (unless Medicare eligible).

Enrollment Restrictions

Retirees and their dependents, eligible for Ryder's retiree medical and prescription coverage, are limited to their initial enrollment upon retirement and one subsequent enrollment.

- if you enroll in coverage upon your retirement and decide to drop your coverage sometime in the future, you only have one additional opportunity to enroll again prior to age 65, or Medicare entitlement;
- if, upon your retirement, you waive coverage in the Ryder Retiree Medical and Prescription Plans (or do not enroll during your enrollment window) or enroll for coverage through a COBRA right election, you will have only one additional opportunity to enroll again prior to age 65. If you waive coverage again, you will no longer be eligible for coverage under Ryder's Retiree Medical and Prescription Plan.

This limitation also applies to your eligible dependents. Dependents can be enrolled in retiree medical and prescription coverage only if they were your eligible dependents at the time of your retirement. They can be added to or dropped from your coverage only during the Annual Enrollment event, which takes place once per year or if you experience a qualified life changing event (e.g., divorce, spouse loses coverage elsewhere, etc.).

Medical and Prescription benefits will be extended to:

- you, until you become age 65 (your coverage ends at the end of the month prior to the month in which you turn 65), or until you become eligible for Medicare, whichever is earlier;
- Your spouse or domestic partner until age 65 or Medicare eligible, whichever comes first, if he or she is an eligible dependent at the time of your retirement. The Working Spouse Eligibility Rule applies. This means that if your working spouse or domestic partner has comprehensive group medical, and/or prescription coverage available to them through their employer, they are not eligible for coverage under the Ryder System, Inc. group Medical and Prescription Plans.
- Your children or the children of your spouse or domestic partner, if they were eligible dependents at the time of your retirement. Such children will be covered until the last day of the month in which your child attains age 26, or you become age 65 (your coverage ends at the end of the month prior to the month in which you turn 65) or your spouse becomes age 65, if you are no longer enrolled, whichever comes first.
- Your disabled children or the disabled children of your spouse or domestic partner, if they were eligible dependents at the time of your retirement. Such children will be covered until the last day of the month in which your child is no longer disabled as determined by the insurance carrier, or the date your disabled child becomes eligible for Medicare, or you become age 65 or your spouse becomes age 65, or if you are no longer enrolled, whichever comes first.

Your spouse or domestic partner will be covered until he/she:

- reaches age 65 (his or her coverage ends at the end of the month prior to the month in which he or she turns 65) or becomes eligible for Medicare, whichever is earlier;
- is divorced from you;
- no longer meets the requirement of a domestic partner;
- becomes eligible for comprehensive coverage through their employer; or
- remarries after your death.

ELIGIBILITY

Note: Delay in Medicare enrollment once eligible does NOT extend eligibility for Ryder's Retiree plans, irrespective of premium costs, provider access, continuation of care, or any other criteria. If you, your covered Spouse/Domestic Partner or covered child becomes entitled to Medicare for any reason, you must notify the Ryder BenefitsNow Service Center within 31 days of the entitlement to terminate coverage in the Ryder Retiree Medical/Prescription plan(s). Failure to timely notify the Ryder BenefitsNow Service Center may require you to reimburse claims paid by insurance carriers on your behalf after the Medicare entitlement.

If you have questions about whether you are eligible for coverage under the retiree medical and prescription drug coverage call the Ryder BenefitsNow Service Center at 1-800-280-2999.

Important Note: The Company's retiree medical benefits are not guaranteed. The Company reserves the right to amend, modify or terminate any and all retiree medical benefits at any time, for any reason, with or without notice.

Death

Your coverage under the Medical, Prescription, Dental, Vision, Short-Term Disability, Long-Term Disability, Life Insurance, AD&D insurance and Dependent Life Insurance plans, as applicable, ends on the date of your death. Refer to the "Events that Affect Your Benefits" Section for more information.

Your dependents' coverage under the Medical, Prescription, Dental and Vision ends on the date of your death. Your dependents will be offered COBRA continuation coverage, to begin the day after your death. Ryder covers the cost of COBRA continuation for your dependents up to the first 60 days of such coverage, as long as you elect COBRA.

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

ADMINISTRATIVE INFORMATION

Administrative Information

This section of your benefit book reviews:

- who sponsors, insures and administers each Ryder System, Inc. Benefit Plan;
- how and when you can obtain continuation coverage under COBRA;
- how to file a claim appeal;
- Statement of Rights Under the Newborn and Mother's Health Protection, Women's Health and Cancer Rights act of 1988; and
- your legal rights as a plan participant under the federal law code commonly known as the Employee Retirement Income Security Act of 1974 (ERISA), as well as under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Medicare Part D.

Plan Sponsor

Ryder System, Inc. sponsors all of the plans described in this book.

Plan Administrator

The plan administrator for all plans is the Vice President of Compensation and Benefits of Ryder System, Inc., except for the 401(k) Savings Plan and the Retirement Plan where the Retirement Committee is the Plan Administrator, Ryder Shares which is the Compensation Committee and Ryder Severance Plans which is the Chief Administration Officer. The plan administrator (or, where applicable, any duly authorized delegee of the plan administrator) shall have the exclusive right, power, and authority in its sole and absolute discretion, to administer, apply and interpret all the plans and any other documents and to decide all factual and legal matters arising in connection with the operation of administration of the plans.

Without limiting the generality of the foregoing paragraph, the plan administrator (or, where applicable, any duly authorized delegee of the plan administrator) shall have the sole and absolute discretionary authority to:

- take all actions and make all decisions (including factual decisions) with respect to the eligibility for, and the amount of, benefits payable under the plans to employees or participants or their beneficiaries;
- formulate, interpret and apply rules, regulations and policies necessary to administer the plans;
- decide questions, including legal or factual questions, relating to the calculation and payment of benefits, and all other determinations made under the plans;
- resolve and/or clarify any factual or other ambiguities, inconsistencies and omissions arising under this Summary Plan Description, the plans or other plan documents;
- process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the plan administrator (or, where applicable, any duly authorized delegee of the plan administrator) with respect to any matter arising under the plans shall be final and binding on the employer, employee, participant, beneficiary, and all other parties affected thereby.

Benefits Administrator

The name, address and phone number for each plan's benefits administrator is shown in the chart at the end of this section, which is entitled "Ryder System, Inc. Benefit Plan Administrative Information" (the "Chart"). The chart also includes each plan's:

- official name;
- number, as reported to the U. S. Department of Labor;
- type, as defined under ERISA; and
- funding information.

Employer Identification Number

The plan sponsor's Employer Identification Number (EIN), which is assigned by the IRS, is 59-0739250.

ADMINISTRATIVE INFORMATION

Service of Legal Process

Service of legal process for the plans may be made to:

The Plan Administrator
Ryder System, Inc.
c/o Vice President, Compensation and Benefits
11690 NW 105th Street
Miami, FL 33178-1103

Plan Year and Plan Records

Ryder System, Inc. plan records are kept on a calendar year basis – beginning January 1 and ending December 31 of each year. The calendar year is also the plan year.

Plan Documents

This book summarizes the key provisions of your Ryder System, Inc. Benefits Plans and programs. The specific provisions of the Ryder System, Inc. 401(k) Savings Plan and the Retirement Plan are contained in the official plan documents, which include contracts between Ryder System, Inc. and the benefits administrators and trustees. If any question arises about the nature and extent of your benefits, the formal language of the plan documents will govern.

This book, in combination with the contracts between Ryder System, Inc. and the benefits administrators, trustees and other related documents, serves as the official plan document for the health and welfare plans described herein.

Assignment of Benefits

Generally, Ryder System, Inc. benefits may not be assigned, anticipated or allocated except, as described in the Life Insurance and AD&D sections, or when required by law under a Qualified Domestic Relations Order as applicable to the Retirement Plan and the Employee 401(k) Savings Plan.

Plan Amendment and Termination

Ryder System, Inc. expects to continue all plans discussed in this book. However, the Company reserves the right to amend, modify or terminate the plans at any time and for any reason in whole or in part and with respect to active employees or retirees. Additionally, the Company's benefit design can change in future years, which may affect your coverage or that portion you pay for your benefits.

The Ryder System, Inc. 401(k) Savings Plan and Retirement Plan are subject to continuing approval by the Internal Revenue Service and may be modified as needed to make or keep the plans qualified under the Internal Revenue Code.

Employment

This document and the benefits described in it are not an employment contract and do not affect the right of either you or the Company to terminate your employment at any time, without cause or notice.

Funding of Benefits

Your benefit plans and programs are funded by a combination of Company and employee contributions. Ryder makes contributions to, or makes payments under, each benefit plan using the general assets of the Company. Your contributions generally are the per-paycheck amounts you pay to participate in these programs.

ADMINISTRATIVE INFORMATION

Cost of Coverage for Active Employees

Pre-Tax Deductions: Medical, Prescription, Dental, Vision and Additional Short-Term Disability Plans

The Company pays a portion of the cost of providing your coverage and you pay a share of the cost through regular payroll contributions. The amount of your contributions depends on the level of benefits you select and the number of dependents you cover. Your Enrollment Worksheet and/or your Confirmation Statement shows you the current cost of your benefit elections.

Pre-tax deductions means that they are taken from your pay *before* federal income and Social Security taxes are deducted. Your contributions may also be exempt from state and local taxes, depending on where you live.

If you experience a Qualified Life Event and change any of your benefit elections, the cost of your coverage will be adjusted accordingly based on your Qualified Life Event. Your new contributions will be deducted as soon as possible following the date of the Qualified Life Event.

If you are absent from work due to disability, an approved leave or a leave permitted by the Family Medical Leave Act, your coverage may continue, however, you must make any required contributions, in order for coverage to remain in effect.

Under the Medical and Prescription Plans, employees cannot benefit from the federal income tax exclusion for benefits provided for a domestic partner or that partner's children, unless the domestic partner and/or their children qualify as a dependent under Internal Revenue Code section 152. Under IRS guidelines, the Employee is subject to tax on the fair market value of the coverage provided to the non-qualified domestic partner and their dependent children. As such, those taxable benefits will be reported as imputed income on the employee's federal W-2 Form at the end of each year in which coverage is elected for a domestic partner and/or their dependent children.

Important Note: Please keep in mind that the Company reserves the right to correct the amount of your or your eligible dependents' contributions at any time and for any reason.

Post-Tax Deductions: Additional Life Insurance, Spouse Life Insurance, Child Life Insurance, Employee/Family Accidental Death & Dismemberment (AD&D), Additional Long-Term Disability and the Hyatt Legal Plan

You pay for the cost through regular payroll contributions on a post-tax basis. Post-tax deductions means that deductions are taken from your pay *after* federal income and Social Security taxes are deducted.

Note: Ryder provides the following benefits to you at no cost: Basic Life Insurance, Basic Short-Term Disability, Basic Long-Term Disability, Seat Belt Coverage, Business Travel Accident Coverage, Employee Assistance Program (EAP), and the Vision Discount Plan.

Effect on Other Benefits

Because many of your Company benefits are based on your annual pay, it is important to note that using pre-tax dollars to purchase your benefits does not affect your other pay-related benefits.

Plan Trustees

The Retirement Plan and 401(k) Savings plans are at least partially funded through trusts, which are established solely for plan purposes. The trustees hold the assets of the trusts.

- the trustee for the Ryder System, Inc. Retirement Plan is Bank of New York Mellon
- the trustee for the Ryder System, Inc. 401(k) Savings Plan is Fidelity Management Trust Company

ADMINISTRATIVE INFORMATION**Continuation Coverage Through COBRA**

The Federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) requires employers who sponsor group health plans to offer employees and their families the opportunity to temporarily extend their health coverage on a self-pay basis. COBRA allows for health coverage to be offered at group rates in certain circumstances where coverage under the plan would otherwise end. This temporary extension is called continuation coverage. It applies to medical, prescription, dental and vision coverage as well as the health care reimbursement account.

Domestic partners, of the same or opposite sex, and their children are not qualified beneficiaries under COBRA. However, Ryder extends rights similar to COBRA to eligible domestic partners and their children, who are identified as dependents in the *Eligibility* section. As such, the following description of COBRA coverage also applies to eligible domestic partners and their children, unless otherwise indicated.

Qualifying Life Events

The events that trigger COBRA rights are called qualifying life events. As a Ryder employee, you have a right to elect continuation coverage if:

- you lose your group health coverage because of your voluntary or involuntary termination of employment (except for gross misconduct); or
- you have a reduction in your hours of employment.

If you are the spouse or domestic partner of a Ryder employee and are covered by the Ryder health plan, in accordance with the definition of "*Dependents*" in the *Eligibility* section, you have the right to elect continuation coverage because of:

- the death of your spouse or domestic partner;
- the termination of your spouse's or domestic partner's employment (for any reason other than gross misconduct);
- a reduction in your spouse's or domestic partner's hours of employment;
- divorce;
- you and your domestic partner no longer meet the eligibility requirements for domestic partner coverage, which are set forth in the *Eligibility* section of this book; or
- your spouse or domestic partner becomes eligible for Medicare.

Dependent child(ren) of employees or their spouses/ domestic partners covered by the Ryder health plan, in accordance with the definition of dependent under the *Eligibility* section, have a right to elect continuation coverage because of:

- the death of a parent or of a parent's spouse or domestic partner who is a Ryder employee;
- the termination of a parent or of a parent's spouse or domestic partner who is a Ryder employee for any reason (except gross misconduct);
- a reduction in the parent's or of a parent's spouse's or domestic partner's hours of employment with Ryder;
- a parent or a parent's spouse or domestic partner who is a Ryder employee becomes eligible for Medicare; or
- ceasing to meet the eligibility requirements for dependents under the health plans.

Individuals receiving retiree health benefits (and their dependents), may elect continuation coverage because of:

- a loss of coverage resulting from a bankruptcy proceeding under Title 11, United States Code with respect to Ryder.

Please note that to be eligible for continuation coverage, the qualifying event must result in the loss of health coverage for the eligible employee and the dependent (whether spouse, domestic partner or child).

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Notice of Qualifying Life Event

Ryder is responsible for notifying the Ryder BenefitsNow Service Center of an employees' death, termination, or reduction in hours of employment.

You, your covered spouse, your covered domestic partner or your covered dependent children are responsible for informing the Ryder BenefitsNow Service Center, within 31 days after the event occurs, when:

- you and your spouse have divorced;
- you and your domestic partner no longer meet the eligibility requirements for domestic partner coverage, which are set forth in the *Eligibility* section;
- a child no longer qualifies as a dependent under the health or child life insurance plans; or
- you have a Medicare entitlement.

Each individual who is eligible for continuation coverage is entitled to make a separate election. In other words, your spouse, your domestic partner or dependent child is entitled to elect continuation coverage even if you do not.

The option of electing COBRA Continuation Coverage must be offered during a period beginning no later than when the individual would otherwise lose coverage under the Plan (the termination date) and ends no earlier than 60 days after;

- the date the individual is notified of his/her COBRA Continuation Coverage rights by the employer; or
- the termination date, whichever date is later.

Thus, the election period under all circumstances must last at least 60 days.

Any election by a qualified beneficiary (other than a dependent child) is considered an election by other qualified beneficiaries who would otherwise lose coverage by reason of the same Qualifying Event. Therefore, a spouse, former spouse or domestic partner who has been a qualified beneficiary under the Plan may elect COBRA Continuation Coverage on his/her own behalf and on behalf of qualified dependent children. COBRA Continuation coverage may not be conditioned directly or indirectly upon the insurability of the qualified beneficiary.

Please note that if you are an individual who qualifies for trade assistance under the Trade Act of 2002, you may be entitled to a second COBRA election period. Please contact the Plan Administrator if you need more information.

In addition, a dependent child born to or adopted by an employee and/or his or her domestic partner during a period of COBRA coverage has the right to continuation coverage. Such a child may be added to continuation coverage on notification to the plan administrator within 31 days of the birth or adoption.

Type of Coverage

Ryder is required to allow you to purchase coverage, which, as of the time coverage is being provided, is equal to the coverage being provided under the plan for similarly situated active employees or family members. If coverage under the plan is modified for similarly situated active employees, your coverage will be modified as well.

Maximum Coverage Periods

The law requires that your dependents be given the opportunity to maintain continuation coverage for 36 months from the date of the qualifying event, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA continuation coverage period is 18 months from the date of the termination or reduction in hours. This 18-month coverage period (or 29 months under the disability extension) may be extended (for up to 36 months from

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the date of the termination or reduction in hours) if another qualifying event (such as death, divorce, legal separation, or Medicare entitlement) occurs during the initial 18-month (or 29 month) coverage period.

If your qualifying event is the end of employment (for reasons other than gross misconduct) or reduction of employee's hours of employment and you become entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for your dependents will last until 36 months after the date of the Medicare entitlement.

Disability Extension

The 18-month coverage period may be extended (for up to 29 months from the date of the termination or reduction in hours) if the Social Security Administration determines that you or an eligible dependent was disabled at any time during the first 60 days of continuation coverage.

To be eligible for additional continuation coverage due to disability, you or your dependent must notify the plan administrator of the Social Security Administration's determination within 60 days of the determination and before the end of the original 18-month continuation coverage period. If the continuation coverage period is extended from 18 months to 29 months due to a Social Security Administration determination of disability, you will pay 150% of the premium during the extension period. You may be required to provide a copy of the Social Security Administration Disability Award.

<u>COBRA Qualifying Events</u>	<u>Maximum Coverage Period</u>	
	<u>Employee</u>	<u>Spouse/Child</u>
Employee loses coverage due to reduced work hours	18	18
Employee terminates for any reason (except gross misconduct)	18	18
Employee/dependent is disabled under the Social Security Act	29	29
Employee dies *	N/A	36
Employee and spouse divorce	N/A	36
Employee and domestic partner terminate relationship **	N/A	36
Employee becomes entitled to Medicare	N/A	36
Child no longer qualifies as a dependent	N/A	36

* *Ryder pays the cost of the first 60 days of COBRA coverage for the surviving covered dependents, following the death of an active employee.*

** *Dependents who are domestic partners and their children are not qualified beneficiaries under COBRA. However, Ryder extends COBRA-like rights to domestic partners and their children, so that these time frames apply to such dependents.*

Cost of Coverage after Termination

You do not have to show that you are insurable to choose continuation coverage. However, you have to pay 102% of the premium for your continuation coverage. If you have your coverage extended because you are disabled, you will have to pay 150% of the premium for coverage after the 18th month. There is a grace period of 30 days before premium payments are due. Your first payment must include the entire premium amount owed to bring your premiums current and is due 45 days after you make your COBRA election through the Ryder BenefitsNow Service Center.

When COBRA Coverage Ends

COBRA continuation coverage may end before the maximum coverage period for any of the following reasons:

- Ryder no longer provides group health coverage to any of its employees;
- the premium for your continuation coverage is not paid on time;

ADMINISTRATIVE INFORMATION

- you become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing conditions;
- you become entitled to Medicare (COBRA coverage for dependents will not be affected by your Medicare eligibility and dependent coverage may be extended due to a second qualifying event);
- you extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled more than 18 months after the termination of your employment or reduction in hours;
- for retired employees receiving COBRA continuation coverage because of bankruptcy proceedings, the death of the covered employee or beneficiary or in the case of a surviving spouse or dependent, 36 months after the date of the death of the covered employee.

Medicaid and the Children’s Health Insurance Program (CHIP)

If you are eligible for health coverage from the Company, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for the Plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your dependents to enroll in the Plan – as long as you and your dependents are eligible, but not already enrolled in the Plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of August 10, 2017. You should contact your State for further information on eligibility.

<p>ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov Phone: 855-692-5447</p>
<p>ALASKA – Medicaid - The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone 866-251-4861</p>
<p>ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 877-764-5437 Phone (Maricopa County): 602-417-5437</p>
<p>Arkansas – Medicaid Website: http://myarhipp.com/ Phone: 1-855-692-7447</p>
<p>COLORADO – Health First Colorado Website: https://www.healthfirstcolorado.com/ Phone: 800-221-3943 / CHIP 1-800-359-1991</p>
<p>FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/ Phone: 877-357-3268</p>

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<p>GEORGIA – Medicaid Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</p>
<p>IDAHO – Medicaid and CHIP Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 800-926-2588</p>
<p>INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877-438-4479 All other Medicaid 800-403-0864</p>
<p>IOWA – Medicaid Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 888-346-9562</p>
<p>KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 785-296-3512</p>
<p>KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 800-635-2570</p>
<p>LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888-695-2447</p>
<p>MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofc/public-assistance/index.html Phone: 800-442-6003</p>
<p>MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800-862-4840</p>
<p>MINNESOTA – Medicaid Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 800-657-3739</p>
<p>MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084</p>
<p>NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 877-632-7633 / Lincoln: 402-473-7000 / Omaha: 402-595-1178</p>
<p>NEVADA – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 800-992-0900</p>
<p>NEW HAMPSHIRE – Medicaid Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>

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<p>NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 800-701-0710</p>
<p>NEW YORK – Medicaid Website: http://www.ny.gov/health_care/medicaid/ Phone: 800-541-2831</p>
<p>NORTH CAROLINA – Medicaid Website: http://dma.ncdhhs.gov/ Phone: 919-855-4100</p>
<p>NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 8448544825</p>
<p>OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 888-365-3742</p>
<p>OREGON – Medicaid Website: http://www.oregon.gov/pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 800-699-9075</p>
<p>PENNSYLVANIA – Medicaid Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 800-692-7462</p>
<p>RHODE ISLAND – Medicaid Website: www.eohhs.ri.gov/ Phone: 855-697-4347</p>
<p>SOUTH CAROLINA – Medicaid Website: http://www.scdhhs.gov Phone: 888-549-0820</p>
<p>SOUTH DAKOTA – Medicaid Website: http://dss.sd.gov Phone: 888-828-0059</p>
<p>TEXAS – Medicaid Website: http://www.gethipptexas.com/ Phone: 800-440-0493</p>
<p>UTAH – Medicaid and CHIP Website: Medicaid – https://medicaid.utah.gov/ CHIP - http://health.utah.gov/chip Phone: 877-543-7669</p>
<p>VERMONT – Medicaid Website: http://www.greenmountaincare.org/ Phone: 800-250-8427</p>
<p>VIRGINIA – Medicaid and CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800-432-5924 CHIP Phone: 855-242-8282</p>
<p>WASHINGTON – Medicaid Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 800-562-3022 ext. 15473</p>

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Phone: 855-699-8447

WISCONSIN – MedicaidWebsite: <http://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>

Phone: 800-362-3002

WYOMING – MedicaidWebsite: <http://wyequalitycare.acs-inc.com/>

Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 2018, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/ebsa

866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov

877-267-2323, Menu Option 4, Ext. 61565

Uniformed Services Leave

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you and your covered dependents will be entitled to elect COBRA coverage the same as if you had experienced one of the “qualifying events” as described above. You are eligible if you fail to work at least 30 hours per week for more than 31 days because of duty in any of the following Uniformed Services:

- the Armed Forces;
- the Army National Guard and the Air Force National Guard when engaged in active duty training, inactive duty training, or full-time National Guard duty;
- the Commissioned Corps of the Public Health Service; and
- other categories of personnel designated by the President of the United States in time of war or emergency.

This extended coverage will last no more than 24 months and cannot be extended regardless of the occurrence of any other subsequent event. All rights guaranteed by USERRA are dependent on Uniformed Service that ends honorably. In general, the rights guaranteed by USERRA do not apply if the aggregate length of your military leave exceeds five years. If you elect coverage, you will be responsible for the appropriate COBRA premiums.

FMLA Leave

If you take family or medical leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you have the option to continue medical coverage during your absence or suspend coverage while you are on FMLA leave. If you choose to continue medical coverage during your absence, you are responsible for the appropriate monthly contribution for coverage during the leave. The coverage will continue as if you were actively working until the earlier of the expiration date of your FMLA leave or the date you give notice to the Company that you will not return from your leave.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement. If the Plan Administrator receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent.

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Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Health Insurance Portability and Accountability Act (HIPAA)

The receipt use and disclosure of protected health information is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as HIPAA). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. The following are some of the measures taken to protect your health information. Additional measures are described in the HIPAA Notice of Privacy Practice following this section:

- if Ryder System, Inc. discloses to any of its agents or subcontractors any of your protected health information that it receives from the group health plans that it sponsors, Ryder System, Inc. will require the agent or subcontractor to handle your protected health information and keep it private to the same extent as if your information was handled directly by Ryder System, Inc.;
- Ryder System, Inc. will not use or disclose your protected health information for employment-related actions or decision or in connection with any other benefit or benefit plan sponsored by Ryder System, Inc., unless you provide written authorization;
- certain employees under the control of Ryder System, Inc. may be given access to your protected health information on behalf of Ryder System, Inc. in Ryder System, Inc.'s capacity as group health plan sponsor, and these employees may use your protected health information solely for the plan administration functions set forth in this summary plan description. These employees include, but are not limited to, employees in the following functional departments:
 - Employee Benefits Department;
 - Benefits Accounting Department;
 - Legal Department; and
 - Internal Audit Department.
- if any of these employees or workforce use or disclose your protected health information in violation of the rules that are set out in this Summary Plan Description, those employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If Ryder System, Inc. becomes aware of any such violation, it will promptly report the violation to your group health plans and will cooperate with your group health plans to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

The following are additional measures that Ryder System, Inc. will take to reasonably and appropriately safeguard the electronic protected health information that it receives, creates or maintains from, or on behalf of, the group health plans in its capacity as the sponsor of those plans. These measures, which are required under the HIPAA security regulations, have been in effect since April 20, 2005.

- Ryder System, Inc. will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits from or on behalf of, the group health plans that it sponsors.

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RYDER SELF-INSURED GROUP HEALTH PLANS

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SHARE IT WITH YOUR SPOUSE AND OTHER DEPENDENTS WHO ARE COVERED UNDER THE PLAN.

WHO WILL FOLLOW THIS NOTICE?

This Notice applies to:

- The Ryder System, Inc. ("Ryder") Benefits Office administering the Ryder Group Health Plan(s) and
- The self-insured services that the Ryder Group Health Plan(s) provide through the following third party administrators: (referred to in this Notice collectively as the "Plan's Administrators"):

United Healthcare, Cigna Dental, Alight, Your Spending Account (YSA) Administered Health Care Flexible Spending Account, and Caremark, Inc.

The activities of the Ryder Benefits Office and all of the Plan's Administrators' services are referred to collectively in this Notice as the "Plan."

The insurers and HMOs of Ryder's fully insured health benefits will be sending out their own privacy notices.

INTRODUCTION

During the course of providing you with health coverage, the Plan will have access to information about you that has been deemed to be "protected health information" by rules issued under the Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA." This Notice describes the medical information practices of the Plan and that of any third party that assists in the administration of the Plan. The Notice also explains the Plan's obligations and your rights regarding the use and disclosure of your protected health information.

If you have any questions about this Notice, please contact the Plan's Privacy Officer at Ryder, at the address and phone number listed at the end of this Notice, or you can contact any of the Plan's Administrators directly to request more details about each of the Plan's Administrators' privacy policies.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal information. We are committed to protecting your medical information. Under HIPAA, your protected health information ("PHI") includes any individually identifiable information (including your name, address, date of birth, employee ID number, and Social Security number) that is linked to your past, present or future physical or mental health, the health care that you have received or payment for your health care. This Notice covers any such PHI that is maintained by or for the Plan. Your personal physician or other health care providers may have different policies or notices regarding their use and disclosure of your PHI.

The Plan is required by law to:

- Make sure that your PHI is kept private;
- Provide you with this Notice of the Plan's legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice (as set forth below or as it may be amended from time to time).

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HOW WE MAY USE AND DISCLOSE YOUR PHI

Uses and Disclosures for Treatment, Payment and Health Care Operations

The Plan may use or disclose your PHI in connection with your receiving treatment from a health care provider, payment for such treatment and for the Plan's health care operations (or for certain very limited health care operations of other health plans or health care providers with whom the Plan coordinates payment for your care). Generally the Plan will make every reasonable effort to disclose only the minimum necessary amount of PHI to achieve the purpose of the use or disclosure.

For Treatment: Although the Plan does not provide treatment, the Plan may use or disclose your PHI to support the provision, coordination or management of your health care treatment. Specifically, the Plan may disclose your PHI to your health care providers, including doctors, nurses, technicians or other hospital personnel who are involved in taking care of you. For example, in the event of an emergency and you are unable to provide your medical history to your physician, the Plan's service providers may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment: "Payment" generally means activities in connection with processing claims for your health care (including billing, claims management, subrogation, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). The Plan may use or disclose your PHI to determine your eligibility for Plan benefits, to facilitate the payment for treatment or services you receive from your health care providers, to determine benefit responsibility under the Plan, or to coordinate your Plan coverage with another health plan. For example, the Plan may disclose your PHI to your health care provider to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. The Plan may also share PHI with a utilization review or pre-certification service provider. Additionally, the Plan may share PHI with another organization to assist in the adjudication or subrogation of claims.

For Health Care Operations: The Plan may use or disclose your PHI as part of the general administrative or business functions of the Plan that the Plan must perform in order to function as a health plan. For example, the Plan may need to review your PHI as part of the Plan's efforts to uncover instances of health care provider abuse and fraud. Additionally, the Plan may use your PHI in connection with: conducting quality assessment and improvement activities and other activities relating to Plan coverage, submitting claims for stop-loss (or excess loss) coverage, conducting or arranging for medical review, legal services, or audit services.

Disclosure To Third Parties: In any circumstance where the Plan discloses PHI to a third party that performs a service on behalf of the Plan (*i.e.*, a Business Associate), the Plan will have a written contract with that entity which requires the entity to also protect the privacy of your PHI.

Disclosures to the Plan Sponsor and Your Representatives

Disclosure to the Plan Sponsor: The Plan may disclose your PHI to designated Ryder System, Inc. personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the individuals who are employed in the Ryder Benefits Department, Law Department, Benefits Accounting Department, HRIS Department, and Internal Audit Department. These individuals will protect the privacy of your health information and ensure it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other Ryder System, Inc. employee or department other than the Benefits, Law, Benefits Accounting, HRIS, and Internal Audit Departments and (2) will not be used by Ryder System, Inc. for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by Ryder System, Inc.

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In addition, the Plan may disclose “summary health information” to Ryder System, Inc. for obtaining premium bids or modifying, amending or terminating the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

Disclosure Pursuant to Those Involved in Your Care: The Plan may disclose to a member of your family, other relative or a close personal friend PHI that is directly relevant to the person’s involvement with your medical care or payment for your care, provided that you have either authorized the disclosure or you have not notified the Plan that you object to the disclosure.

Disclosure to Your Personal Representatives: The Plan may disclose your PHI to your personal representative in accordance with applicable state law or HIPAA (e.g., parents of children under 18, those with unlimited powers of attorney, etc.). In addition, you may authorize a personal representative to receive your PHI and act on your behalf. Contact the Plan’s Privacy Officer at Ryder, or if in connection with PHI held by one of the Plan’s Administrators, you may contact those Plan’s Administrators directly, to obtain a copy of the appropriate form to authorize the people who may receive this information.

Other Permitted Uses and Disclosures

The Plan may also use or disclose your PHI without your consent or authorization for any of the following purposes:

Reminders: The Plan may use your PHI to provide you with reminders. For example, the Plan may use your child’s date of birth to remind you that you may purchase COBRA continuation coverage for your child who would otherwise lose coverage under the Plan due to age or student status.

Treatment Alternatives: The Plan may use your PHI to inform you about treatment alternatives.

Health-Related Benefits and Services: The Plan may use or disclose your PHI to inform you about other health-related benefits and services that may be of interest to you.

Required By Law: The Plan may use or disclose your PHI to the extent that the Plan is required to do so by federal, state or local law. If required by law, you may be notified of any such uses or disclosures.

Public Health: The Plan may disclose your PHI for public health and safety purposes to a public health authority that is permitted by law to collect or receive the information. Your PHI may be used or disclosed for the purpose of preventing or controlling disease (including communicable diseases), injury or disability. If directed by the public health authority, the Plan may also disclose your PHI to a foreign government agency that is collaborating with the public health authority. The Plan may also disclose your PHI to any authorized public or private entities assisting in disaster relief efforts.

Health Oversight: The Plan may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse Or Neglect: The Plan may disclose your PHI to any public health authority authorized by law to receive information about abuse, neglect or domestic violence if the Plan reasonably believes that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws, and the Plan will inform you that such a disclosure has been or will be made unless that notice will cause a risk of serious harm.

To Avert A Serious Threat to Health or Safety: The Plan may use or disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or

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another person. Any disclosure, however, would only be to someone reasonably able to help prevent or lessen the threat.

Legal Proceedings: The Plan may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal. In addition, the Plan may disclose your PHI under certain conditions in response to a subpoena, court-ordered discovery request or other lawful process, in which case reasonable efforts must be undertaken by the party seeking the PHI to notify you and give you an opportunity to object to the disclosure.

Law Enforcement: The Plan may disclose your PHI if requested by a law enforcement official as part of certain law enforcement activities.

Coroners, Funeral Directors, and Organ Donation: The Plan may disclose your PHI to a coroner or medical examiner for identification purposes, or other duties authorized by law. The Plan may also disclose your PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. The Plan may disclose such information in reasonable anticipation of death. The Plan may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

Research: The Plan is permitted to disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your PHI.

Military Activity and National Security: When the appropriate conditions apply, the Plan may use or disclose PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. The Plan may also disclose your PHI to authorized federal officials conducting national security and intelligence activities.

Workers' Compensation: The Plan may disclose your PHI to comply with workers' compensation laws and other similar legally established programs.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose your PHI to the institution or official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.

Required Uses and Disclosures: The Plan must make disclosures of PHI to the Secretary of the U.S. Department of Health and Human Services ("HHS") to investigate or determine the Plan's compliance with the federal regulations regarding privacy.

Fundraising: The Plan, or an authorized third party on the Plan's behalf, may contact you for fundraising purposes. If you are contacted for such fundraising purposes, you have the right to opt out of receiving such communication.

OTHER USES AND DISCLOSURES OF PHI

Most uses or disclosures of psychotherapy notes (where applicable), uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require an authorization. Other uses and disclosures of your PHI not covered by this Notice or HIPAA, or other laws that apply to the Plan, will only be made with your written authorization. For example, a written authorization from you would be necessary to disclose your PHI to another benefit plan, or to your authorized representative, or in connection with litigation, unless otherwise permitted or required as outlined above.

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If you provide the Plan with written authorization to use or disclose your PHI for purposes other than those set forth in this Notice, you may revoke that authorization in writing at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. However, you understand that the Plan is unable to take back any disclosures already made with your authorization, and is required to retain records of the care provided to you.

The Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding the PHI that the Plan maintains:

Right to Inspect and Copy: As long as the Plan maintains it, you may inspect and obtain a copy of your PHI that is contained in a "designated record set," as defined below. In general, the Plan will provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. If necessary, the Plan may extend the time for processing your request up to an additional 30 days. The Plan may impose a fee to cover the costs of copying your health record and the cost of mailing including postage and may require you to submit your request in writing. If your health record is maintained electronically, you have the right to receive such electronic PHI in the electronic form and format you request if it is readily producible or, if not, in a readable electronic form and format agreed to by you and the Plan. The Plan may charge you for the cost of any electronic medical (other than email) used to provide your electronic PHI.

The Plan may deny your request to inspect and copy your PHI in certain limited circumstances. For example, under federal law, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and to HHS.

A "designated record set" includes your medical records and billing records that are maintained by or for a covered health care provider, and in connection with the Plan, includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan or other information used in whole or in part by or for a health plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

Right to Request a Restriction on the Use and Disclosure of Your PHI: You may ask the Plan to restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations. You may also request that the Plan restrict uses and disclosures of your PHI to family members, relatives, friends or other persons identified by you who are involved in your care.

However, the Plan is not required to agree to a restriction that you request. If the Plan does agree to the request, the Plan will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or the Plan terminates the restriction with or without your agreement. If you do not agree to the termination, the restriction will continue to apply to PHI created or received prior to the Plan's notice to you of the Plan's termination of the restriction.

To request a restriction, you must submit the requests in writing to the Plan indicating (1) what information you want to restrict, (2) whether you want to restrict use, disclosure or both, and (3) to whom you want the restriction to apply.

Right to Request to Receive Confidential Communications by Alternative Means or at an Alternative Location: The Plan will accommodate your reasonable written request to receive

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communications of PHI from the Plan by alternative means or at alternative locations (e.g., contact you at work, instead of at home) if the request includes a statement that disclosure using the Plan's regular communications procedures could endanger you.

Right to Amend Your PHI: If you believe that PHI that the Plan has about you is incorrect or incomplete, you may request that it be amended. Your request must be made in writing and you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask us to amend information that:

- did not originate with the Plan, unless the person or entity that originated the PHI is no longer available to make the amendment;
- is not contained in the records maintained by the Plan;
- is not part of the information that you would legally be permitted to inspect and copy; or
- is accurate and complete.

The Plan will act on your request for an amendment (either denying or granting it) no later than 60 days after receipt of your request. If necessary, the Plan may extend the time for processing your request up to an additional 30 days. If this should happen, you will be notified in writing as to why there is a delay. If your request is denied, you will be provided with a written explanation of the basis for the denial. You will also be provided with an explanation of your right to submit a written statement disagreeing with the denial and your right to have that statement included with any future disclosures of that PHI.

Right to an Accounting of Disclosures: You have the right to submit a written request for an accounting (*i.e.*, a list) of certain disclosures of your PHI. In general, the Plan is required to comply with your request, subject to certain exceptions, such as where the disclosure was made:

in connection with your receiving treatment, the Plan's payment for such treatment and for health care operations;

- to you regarding your own PHI;
- pursuant to your written authorization;
- to a person involved in your care or for other permitted notification purposes;
- for national security or intelligence purposes; or
- to a correctional institution or law enforcement official.

You have the right to receive an accounting of disclosures of PHI made within six years (or less) of the date on which the accounting is requested, but not prior to April 14, 2003. Your request should indicate the form in which you want the list (e.g., paper or electronic). The first accounting you request within a 12-month period will be free of charge. For additional requests within the 12-month period, the Plan will charge you for the costs of providing the accounting. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred.

The Plan will act on your request for an accounting no later than 60 days after receipt of your request. This time period may be extended, where necessary, for an additional 30 days. If this should happen, you will be notified in writing concerning the reasons for the delay and the date by which the Plan will provide the accounting.

Right to Receive Breach Notification

You have the right to and will receive notification if a breach of your unsecured PHI requiring notification occurs.

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HOW TO EXERCISE ANY OF THESE RIGHTS

If you would like to exercise any of the above-described rights in connection with the Plan's information held by any of the Plan's Administrators, you may contact the Plan's Administrators directly (using the telephone numbers and addresses provided to you directly by those of the Plan's Administrators from whom you receive services) or, if you are unable to reach the Plan's Administrators, you can contact the Plan's Privacy Officer at Ryder at the address below.

Right to Obtain a Paper Copy of this Notice: You may request a paper copy of the Plan's Privacy Notice at any time, even if you have previously agreed to accept the Notice electronically. Requests should be made to the Plan's Privacy Officer at Ryder.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a written complaint with us at the address below or with the regional offices of the Office of Civil Rights for the Secretary of the U.S. Department of Health and Human Services. The Plan will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

THE PLAN IS REQUIRED TO ABIDE BY THE TERMS OF THIS NOTICE. HOWEVER, THE PLAN RESERVES THE RIGHT TO CHANGE THE TERMS OF THIS OR ANY SUBSEQUENT NOTICE AT ANY TIME. IF THE PLAN ELECTS TO MAKE A CHANGE, THE REVISED NOTICE WILL BE EFFECTIVE FOR ALL PHI THAT THE PLAN MAINTAINS AT THAT TIME. WITHIN 60 DAYS OF ANY MATERIAL REVISION OF THE PLAN'S PRIVACY PRACTICES, THE PLAN WILL DISTRIBUTE A NEW NOTICE IN THE SAME OR SIMILAR MANNER IN WHICH YOU RECEIVED THIS NOTICE.

FOR QUESTIONS OR REQUESTS

If you have any questions regarding this Notice or the subjects addressed in it, or would like to submit a written request as described above, you may contact the Plan's Administrators directly or you may contact the Plan's Privacy Officer at Ryder as follows:

Privacy Officer
Assistant General Counsel
Ryder System, Inc.
11690 NW 105th Street
Miami, FL 33178-1103
305-500-3988

The use and disclosure of PHI by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations.

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

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For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Benefit Claims and Appeals Process

You or your beneficiary (or duly authorized representative) must file a claim to receive benefits to which you are entitled under any of the Ryder System, Inc. benefit plans or programs. Each Ryder System, Inc. benefit plan has a different party with whom you should file your initial claim for benefits (or your appeal of a denied claim). Please check the "Who To Send Your Claims and Appeals To" chart, located at the end of this section. In addition, the plan-specific chapters of the SPD contain information about filing claims and appeals.

Below are the general guidelines for filing your claim for benefits. Please note that different types of benefit claims will have different guidelines and time deadlines. For your claims for group health benefits under the Ryder System, Inc. Medical Plan, Prescription Plan, Dental Plan and Health Care Flexible Spending Account Plan, the guidelines for resolving your claim will depend on whether the claim is for: (i) pre-service care, (ii) post-service care, (iii) urgent care, or (iv) concurrent care. These terms are defined below.

Claims and Appeals for Benefits - UnitedHealthcare Medical Plans

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance. Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

How To File Your Claim for Non-Network Benefits

You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
 - the Current Procedural Terminology (CPT) codes;

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- a description of, and the charge for, each service;
- the date the Sickness or Injury began; and
- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you. The above information should be filed with UnitedHealthcare at the address on your ID card. After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month that UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms. If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com.

Timely Filing of Claims

All claim forms for services must be submitted within one year after the end of the year in which expenses are incurred, whether you are filing the claim on your own or your dependent(s)' behalf, or whether your provider (physician, hospital, laboratory, etc.) is filing the claim on your or your dependent(s)' behalf. **It is your responsibility to ensure that all of your claims and your dependent(s)' claims are filed timely. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Ryder.** This timeliness requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient stay, the date of service is the date your Inpatient stay ends.

Claim Denials and Appeals

If Your Claim Is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing

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within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal. Refer to the chart at the end of this section.

Types of Claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by

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sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare 's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare 's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review

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(unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

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

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare. You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

ADMINISTRATIVE INFORMATION**Timing of Appeals Determinations**

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
<ul style="list-style-type: none"> • if the initial request for Benefits is complete, within: 	15 days
<ul style="list-style-type: none"> • after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: 	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit

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Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
	determination
UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
<ul style="list-style-type: none"> if the initial claim is complete, within: 	30 days
<ul style="list-style-type: none"> after receiving the completed claim (if the initial claim is incomplete), within: 	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent

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circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Ryder or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Ryder or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Ryder or the Claims Administrator.

You cannot bring any legal action against Ryder or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Ryder or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Ryder or the Claims Administrator.

Claims and Appeals for Benefits - Caremark Rx Prescription Plan**If Your Claim Is Denied**

If your claim for a prescription drug is denied in whole or in part, you have the right to file a formal written appeal with the Plan Administrator as described below.

How To Appeal A Denied Claim

If you wish to appeal a denied pre-service request or post-service claim as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit an urgent care appeal in writing. Your appeal should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date you attempted to fill your prescription;
- the reason you disagree with the denial; and
- any other documentation and other written information to support your request.

You or your authorized representative must send your written appeal to the following address:

**Benefits Department
11690 NW 105 Street
Miami, FL 33178-1103
Fax: 305-500-4342**

Review of an Appeal

The Plan Administrator will conduct a full and fair review of your written appeal. The appeal will be reviewed by an appropriate individual(s) who did not make the initial benefit determination. This individual(s) will take into consideration all the documents and information you submitted to support your appeal. The Plan Administrator will respond to your appeal in the following timeframes:

- Pre-Service Claims: 15 days
- Post-Service Claims: 30 days
- Urgent Care Claims: 72 hours

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Federal External Review Process (Non-Expedited)

If your claim is denied you may request, in writing, an External Review of such Claim within 4 months after receiving notice of the Final Internal Adverse Benefit Determination. Your request should include your name, contact information including mailing address and daytime phone number, your member ID number, and a copy of the coverage denial. Your request for External Review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
 External Review Appeals Department
 MC109
 P.O. Box 52084
 Phoenix, AZ 85072-2084
 Fax Number: 866-443-1172

Preliminary Review

Within 5 days of receiving your request for External Review, CVS Caremark will conduct a "preliminary review" to ensure that the request qualifies for External Review. In this preliminary review, CVS Caremark will determine whether:

- you are or were covered under the Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided;
- the Adverse Benefit Determination or Final Internal Adverse benefit Determination does not relate to the member's failure to meet the Plan's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal External Review;
- you have exhausted the Plan's internal appeal process (unless the Claim is "deemed exhausted" under the ACA); and
- you have provided all the information and forms necessary to process the External Review.

In addition, CVS Caremark will review the request for External Review to determine whether it involves a Claim Involving Medical Judgment. If CVS Caremark determines that the request does not involve a Medical Judgment, it will forward the request for External Review to an IRO for further review. The IRO determines whether the request for External Review involves a Claim Involving Medical Judgment as soon as possible. Within one day after completing its preliminary review, CVS Caremark will notify you, in writing, that: (i) the request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO

If your request for External Review is complete and the Claim is eligible for External Review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify you of its acceptance of the assignment. You will then have 10 days to provide the IRO with any additional information you want the IRO to consider. The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan and the Plan Sponsor. The IRO may consider information beyond the records for the denied Claim, such as:

- medical records;
- the attending health care professional's recommendations;
- reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating physician;
- the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national, or professional medicine societies, boards, and associations;

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- any applicable clinical review criteria developed and used on behalf of the Plan (unless the criteria are inconsistent with the terms of the Plan or applicable law); and
- the opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the member's request for External Review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Timing of IRO's Determination

The IRO will provide you and CVS Caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for External Review. The IRO's notice will contain:

- a general description of the reason for the request for External Review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the claim amount [if available], and the reasons for the previous denials);
- the date the IRO received the External Review assignment from CVS Caremark, and the date of the IRO's decision;
- references to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- a discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
- a statement that you may still be eligible to seek judicial review of any adverse External Review determination; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

Reversal of the Plan's Prior Decision

If CVS Caremark, acting on the Plan's behalf, receives notice from the IRO that it has reversed the prior adverse determination of your Claim, CVS Caremark will immediately provide coverage or payment for the Claim.

Federal External Review Process (Expedited)

You may request an expedited External Review:

- if you receive an Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, and/or could result in failure to regain maximum function, and you have filed a request for an expedited internal appeal; or
- if you receive a Final Internal Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves: (i) a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize your life or health, and/or could result in failure to regain maximum function; or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which you have received emergency services, but have not been discharged from a facility.

Request for Review

If your situation meets the definition of urgent under the law, the external review of the Claim will be conducted as expeditiously as possible. In that case, you or your physician may request an expedited external review by calling Customer Care toll-free at the number on their benefit ID card or contacting their benefits office. The request should include your name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial. Alternatively, a request for expedited External Review may be faxed; contact information and coverage denial description, and supporting documentation may be faxed to the attention CVS Caremark External Review

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Appeals Department at fax number 866-689-3092. All requests for expedited review must be clearly identified as “urgent” at submission.

Preliminary Review

Immediately on receipt of your request for expedited External Review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard External Review. Immediately upon completing this review, CVS Caremark will notify you that: (i) your request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO

Upon determining that your request is eligible for expedited External Review, CVS Caremark will assign an IRO to review the member’s Claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for External Review, the IRO will review your Claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Plan during the internal claims and appeals process.

Timing of the IRO’s Determination

The IRO must provide you and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for External Review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and CVS Caremark, on behalf of the Plan, with written confirmation of its decision.

Authority for Review

CVS Caremark will be responsible only for conducting the preliminary review of your request for External Review, ensuring that you are promptly notified of the decision as to eligibility for External Review, and for assigning the request for External Review to an IRO. The External Review of your appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the External Review performed by an IRO.

Claims and Appeals for Benefits - Cigna Dental Plan

How to File Your Claim

Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form. You may get the required claim forms from the website listed or by calling Member Services using the toll-free number.

Timely Filing

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

Appeal Process

For the purposes of this section, any reference to “you,” “your,” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. “Physician Reviewers” are licensed Dentists depending on the care, service or treatment under review.

ADMINISTRATIVE INFORMATION**Internal Appeals Procedure**

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write using the toll-free number or address on your Benefit Identification card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. Cigna will respond in writing with a decision within 30 calendar days after receiving an appeal for a post service coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review will not affect the claimant's rights to any other benefits under the plan. There is no charge for you to initiate the external review. Cigna will abide by the decision of the IRO.

In order to request a referral to an IRO, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to the randomly selected IRO. The IRO will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by Cigna's Dentist reviewer, the review shall be completed within 3 days. The external review is a voluntary program arranged by Cigna.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit. You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of

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policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the internal and external appeal processes.

Claims and Appeals for Benefits - Ryder System, Inc. Disability Plans

The following guidelines are for claims that you file for benefits under the Ryder System, Inc. Short-Term Disability Plan and Long-Term Disability Plan. Please refer to these sections of the SPD for more specific details on how to properly file a claim.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the appropriate Claim Administrator will notify you (or your duly authorized representative) within 45 days of receiving your claim.

There may be two extension periods of up to 30 days each, provided that the Claim Administrator determines that such an extension is necessary due to circumstances beyond the control of the plan. In the event of such an extension, notice of the extension will be provided to you before expiration of the initial 45-day period (or before expiration of the first 30-day extension, in the case of a second extension). The notice will explain the circumstances requiring the extension and inform you of the date by which the Claim Administrator expects to make a decision. The notice will also specifically explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days in which to provide the specified information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Claim Administrator's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination;
- the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed;
- what procedures you should follow to get your claim reviewed again by the appropriate Appellate Body (as listed in each Plan's section of this SPD and the chart located at the end of this section), and the time limits applicable to such procedures;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

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- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration;
- A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and
- Notice in a culturally and linguistically appropriate manner.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, within 180 days after you receive the notice of denial, submit your written request for review to the appropriate Appellate Body. You have the right to:

- submit written comments, documents, records or other information relating to your claim.
- request, free of charge, reasonable access to (and copies of) all documents, records and other information relevant to your claim.
- a review that takes into account all comments, documents, records and other information you submit without regard to whether such information was submitted or considered in the initial claim decision.
- A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate.
- If the appeal involves an adverse decision based on medical judgement, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual.
- The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.
- Prior to issuing a denial of an appeal of a claim involving disability, the Appellate Body will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and/or with any new or additional rationales for denying the claim, as soon as possible and sufficiently in advance of the date the appeal is to be considered to give you a reasonable opportunity to respond prior to the date the appeal will be considered.

You will be notified of the decision on review within 45 days after the plan's receipt of your request for review, unless the Appellate Body determines that special circumstances require an extension of time for processing. If such a determination is made, you will be notified of the extension in writing before the end of the 45-day period. The extension will not exceed a period of 45 days from the end of the initial 45-day period. The extension notice will indicate the special circumstances requiring the extension as well as the date by which the Appellate Body expects to make the determination on review.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Appellate Body's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the following:

- the specific reason(s) for the adverse determination;
- references to the specific plan provisions on which the determination is based;

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- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a statement of your right to bring an action under Section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- a description of the contractual limitations period that applies to your right to bring an action and the calendar date on which the contractual limitations period expires for the claim; and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

All decisions on review are final and binding on all parties.

Claims and Appeals for Benefits - All Other Ryder System, Inc. Plans

(i.e., claims that are not for group health or disability benefits)

The following guidelines are for claims that you file for benefits under the Ryder System, Inc. 401(k) Savings Plan, Retirement Plan, Flexible Spending Account Plans, AD&D Plan, Group Life and Supplemental Life Plans, and Severance Plans.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the appropriate Claim Administrator (as listed in each Plan's section of this SPD and on the chart located at the end of this section) will notify you (or your duly authorized representative) within 90 days of receiving your written claim.

This 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the Claim Administrator expects to make the benefit determination, before the end of the initial 90-day period.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination; the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed; and
- what procedures you should follow to get your claim reviewed again by the appropriate Appellate Body and the time limits applicable to such procedures.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, within 60 days after you receive the notice of denial, submit your written request for review to the appropriate Appellate Body (as listed in each Plan's section of this SPD and on the chart entitled *Who to Send Your Claims and Appeals To* located in this section). In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. In addition, you will be provided, upon written request and free of charge, with

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reasonable access to (and copies of) all documents, records and other information relevant to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim.

You will be notified of the decision on review within 60 days after the plan's receipt of your request for review, unless the Appellate Body determines that special circumstances require an extension of time for processing. If such a determination is made, you will be notified of the extension in writing before the end of the 60-day period. The extension will not exceed a period of 60 days from the end of the initial 60-day period. The extension notice will indicate the special circumstances requiring the extension as well as the date by which the Appellate Body expects to make the determination on review.

With regard to your non-retirement benefits, if an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Appellate Body's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the following:

- the specific reason(s) for the adverse determination;
- references to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- a statement of your right to bring an action under Section 502(a) of ERISA.

All decisions on review are final and binding on all parties.

External Review Process

Your claim may be eligible for an external review through an independent review organization. For more information about the external review process or to inquire if your claim is eligible for a review by an independent review organization, please contact the plan administrator.

Who To Send Your Claims and Appeals To

Name of Plan	Claim Administrator	Appellate Body
The Ryder System, Inc. Medical Plan	United Healthcare – Claims Administrator	United Healthcare – Claims Administrator (send both levels of appeal to United Healthcare)
The Ryder System, Inc. Prescription Plan	Caremark – Claims Administrator	Caremark – Claims Administrator (send appeals to Ryder)
EAP Program	FEI Behavioral Health– Claims Fiduciary	FEI Behavioral Health (send both levels of appeal to FEI Behavioral Health)
The Ryder System, Inc. Dental Plan	Cigna Dental Care – Claims Administrator	Cigna Dental Care – Claims Administrator (send both levels of appeal to Cigna Dental Care)
The Ryder System, Inc. Health Care Flexible Spending Account Plan	Your Spending Account (YSA) – Claims Fiduciary	Your Spending Account (YSA) – Claims Administrator (send both levels of appeal to YSA)
The Ryder System, Inc. Dependent Care Flexible Spending Account	Your Spending Account (YSA) – Claims Fiduciary	Your Spending Account (YSA) – Claims Administrator (send both levels of appeal to YSA)
The Ryder System, Inc. Short-Term Disability Plan	Liberty Mutual Group – Claims Administrator	Liberty Mutual Group – Claims Administrator

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The Ryder System, Inc. Long-Term Disability Plan	Liberty Mutual Group – Claims Administrator	Liberty Mutual Group – Claims Administrator
The Ryder System, Inc. AD&D Plan	Securian Life – Claims Administrator	Securian Life – Claims Administrator
The Ryder System, Inc. Group Life and Supplemental Life Plan	Securian Life – Claims Administrator	Securian Life – Claims Administrator
The Ryder System, Inc. 401(k) Savings Plan	The Ryder System, Inc. Retirement Committee	The Ryder System, Inc. Retirement Committee
The Ryder System, Inc. Retirement Plan	The Ryder System, Inc. Retirement Committee	The Ryder System, Inc. Retirement Committee
Business Travel Accident	A.C. Newman & Company	A.C. Newman & Company – Claims Administrator
EyeMed Vision Insurance Plan	EyeMed Vision Care	EyeMed Vision Care – Claims Administrator
Severance Plans	The Ryder System, Inc. Plan Administrator	The Ryder System, Inc. Plan Administrator

Please remember that if your claim is denied your written notification of the denial will include information regarding where to send your request for an appeal. If that contact information differs in any way from the information contained in this SPD, send your request for appeal to the address stated in the written notification of your initial claim denial.

If you have any questions regarding any aspect of the claims and appeals process, please call the Ryder BenefitsNow Service Center at 800-280-2999.

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

- examine without charge, at the plan administrator's office and at other specified locations, all documents governing the plan, including plan documents, insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
- obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including plan documents, insurance contracts, collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies; and
- receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of his or her summary annual report.

Continue Group Health Plan Coverage

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

- reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance insurer when:

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- you lose coverage under the plan;
- you become entitled to elect COBRA continuation coverage;
- your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare or pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack of a decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact:

- the Employee Benefits Security Administration (“EBSA”), U.S. Department of Labor. Contact Information for EBSA, including the regional office in your area, is located at www.askebsa.dol.gov, or you can call EBSA toll free at 866-444-EBSA (3272). Alternatively, you can find the EBSA regional office in your area in your local telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210; or
- you may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Statement of Rights - Newborn’s and Mothers’ Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by caesarean section. However, the plan or issuer may pay for a shorter stay if the

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attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or the newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

ADMINISTRATIVE INFORMATION**Medicare Part D Notices****Notice of Creditable Coverage****Medicare Part D – Important if you are 65 or over, or otherwise Medicare eligible****Important Notice from Ryder System, Inc.
About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ryder System, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ryder System, Inc. has determined that the prescription drug coverage offered by the Caremark Plans, Humana Puerto Rico Plan, Blue Care Network and all Kaiser Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Special Note for Retirees: Once you or a covered dependent reaches age 65, prescription coverage cannot be continued through Ryder.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer/union-sponsored coverage you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare drug plan and drop your Ryder System, Inc. prescription drug coverage, be aware that you and your dependents may not be able to or in some cases cannot get this coverage back.

You should also know that if you drop or lose your coverage with Ryder System, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ryder System, Inc. ends or changes. You also may request a copy.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

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

ADMINISTRATIVE INFORMATION**Ryder System, Inc. Benefit Plan Administrative Information**

Plan Name	Plan Number	Plan Type	Funding	Contact Information
The Ryder System, Inc. Flexible Benefits Plan (Medical Plan)	527	Welfare and fringe benefit	Combination of employer and employee funding	United Healthcare Claims and Appeals PO Box 30432 Salt Lake City, Utah 84130-0432 888-899-4734 www.myuhc.com , or www.uhc.com
The Ryder System, Inc. Flexible Benefits Plan (Prescription Plan)	527	Welfare and fringe benefit	Combination of employer and employee funding	Caremark, Inc. 2211 Sanders Road Northbrook, IL. 60062 800-323-8083 www.caremark.com
The Ryder System, Inc. Flexible Benefits Plan (Employee Assistance Program)	527	Welfare and fringe benefit	Combination of employer and employee funding	FEI Behavioral Health 648 N. Plankinton Ave., Ste 425 Milwaukee, WI. 53203 800-323-0751 www.feibh.com/rsi
The Ryder System, Inc. Flexible Benefits Plan (Dental Plan)	527	Welfare and fringe benefit	Combination of employer and employee funding	Cigna Dental 900 Cottage Grove Road Hartford, CT 06152-2129 800-525-5803 www.cigna.com
The Ryder System, Inc. Flexible Benefits Plan (Health Care and Dependent Care Flexible Spending Account)	527	Welfare and fringe benefit	Participant contributions	YSA Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407 800-280-2999
The Ryder System, Inc. Flexible Benefits Plan (Health Care and Dependent Care Flexible Spending Account)	527	Welfare and fringe benefit	Participant contributions	YSA Claims Management PO Box 64030 The Woodlands, TX 77387-4030 800-280-2999
The Ryder System, Inc. Short-Term Disability Plan	512	Welfare	Combination of employer and employee funding	Liberty Mutual Group 13830 Ballantyne Corporate Place, Ste 400 Charlotte, NC 28277 800-291-0112, ext. 23967
The Ryder System, Inc. Long-Term Disability Plan	504	Welfare	Insured	Liberty Mutual Group 13830 Ballantyne Corporate Place, Ste 400 Charlotte, NC 28277 800-291-0112, ext. 23967

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Plan Name	Plan Number	Plan Type	Funding	Contact Information
The Ryder System, Inc. Flexible Benefits Plan (AD&D Plan)	527	Welfare	Insured	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101 888-658-0193
The Ryder System, Inc. Flexible Benefits Plan (Group Life and Supplemental Life Plan)	527	Welfare	Insured	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101 888-658-0193
The Ryder System, Inc. 401(k) Savings Plan	005	Defined contribution	Trust fund	Fidelity Institutional Services P.O. Box 28026 Albuquerque, NM 87125-8026 800-373-7300
The Ryder System, Inc. Retirement Plan	001	Defined benefit (pension)	Trust Fund	Fidelity Institutional Services P.O. Box 28022 Albuquerque, NM 87125-8022 800-373-7300
The Ryder System, Inc. Vision Insurance Plan	528	Welfare	Insured	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 866-723-0513 www.eyemed.com
The Ryder System, Inc. Business Travel Accident Plan	509	Welfare	Insured	A.C. Newman & Company, Insurance Correspondents Inc. 7060 N. Marks Avenue, Ste 108 Fresno, CA. 93711
The Ryder System, Inc. Hyatt Legal Plan	515	Welfare	Participant contributions	Hyatt Legal Plan, Inc. 1215 Superior Ave. Cleveland, OH 44114-3292 800-821-6400 www.hlp svc.com
Ryder Severance Plan	526	Welfare	Employer funding	The Plan Administrator Ryder System, Inc. Chief Administrative Officer 11690 NW 105 th Street Miami, FL 33178-1103
Ryder Severance Plan for Eligible Supply Chain Employees	529	Welfare	Employer funding	The Plan Administrator Ryder System, Inc. Chief Administrative Officer 11690 NW 105 th Street Miami, FL 33178-1103

MEDICAL PLAN

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

MEDICAL PLAN

Introduction and Plan Options

UnitedHealthcare Medical Plans

This section of your Summary Plan Description (SPD) is designed to provide you with information about the Ryder System, Inc. Medical Plan consisting of the following UnitedHealthcare (UHC) options. Eligibility for some of the plans is based on the zip code for your address of record. Each Option described below has specific annual deductibles, coinsurance and annual out-of-pocket maximum. These specifics are illustrated in the charts found in the “Highlights of the UnitedHealthcare (UHC) Medical Plan Options” in this Medical section of the Summary Plan Description Book.

- **UHC Option 1 Plan – utilizing providers in the UnitedHealthcare Choice Plus network** – a nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services after you meet the deductible and 100% for preventive care providing you utilize network services. If you don't use network doctors and facilities, the plan pays up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”).
- **UHC HSA Plan – utilizing providers in the UnitedHealthcare Choice Plus network** – a nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services after you meet the deductible and 100% for preventive care providing you utilize network services. If you don't use network doctors and facilities, the plan pays up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). This plan includes prescription coverage through Caremark, however, you are responsible for the full cost of many prescriptions until you meet the deductible (see the Prescription Section for more details).
- **UHC Standard Plan - utilizing providers in the UnitedHealthcare Choice Plus network** – a nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services after you meet the deductible and 100% for preventive care providing you utilize network services. If you don't use network doctors and facilities, the plan pays up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, “What the UnitedHealthcare Medical Plans Cover”). This plan includes prescription coverage through Caremark (see the Prescription Section for more details).
- **UHC Option 1 Passive PPO Plan** – a limited nationwide network of doctors, facilities and specialists. The plan pays 80% of covered services after you meet the deductible and 100% for preventive care. When you receive services from providers who are not a part of the network, you are provided coverage by a fee-for-service plan, which pays benefits based on whether or not the service meets the definition of an Eligible Expense and whether or not it is a Covered Health Service. You and your dependents may receive care from any qualified licensed doctor, hospital or other health care facility. Fee-for-service arrangements allow the member the greatest flexibility in choosing health care professionals and hospitals that are not part of the contracted network; however, when Non-Network providers are used, the portion of expense to the member is generally much higher than if Network providers were used.
- **No Coverage Option** – You may also choose to waive medical coverage.

Other Health Plans

These plans are not described in this Summary Plan Description Book. Plan information for these plans is available directly through the respective Health Plans.

- **Blue Care C and Blue Care D Plans**
- **Humana PPO Plan**
- **Kaiser Permanente**

Non-Tobacco User Credit

If you or your covered Spouse or Domestic Partner does not use tobacco products, you can elect the non-tobacco user credit and receive a monthly premium credit towards your Medical Plan contributions. By selecting the non-tobacco user option, you and your covered Spouse/Domestic Partner certify that you will not use tobacco products during the plan year.

Ryder defines a tobacco user as someone who uses any tobacco products (i.e., smoking cigarettes, pipes, cigars, vaping kits or using chewing tobacco) regardless of frequency. Your enrollment in the Non-Tobacco User Credit Plan must be accurate and truthful. Any intentional misrepresentation will subject you to immediate and appropriate disciplinary action, up to and including termination of benefits and termination of employment.

Generally, changes to this credit plan can only be made during Annual Enrollment. However, if you successfully complete the Quit4Life tobacco cessation program through UHC, you may elect the Non-tobacco User Credit at that time, providing your covered Spouse/Domestic Partner is also tobacco-free. If your Spouse/Domestic partner is a tobacco user and you are making a change outside of Annual Enrollment to remove your Spouse/Domestic Partner from your coverage, you may be eligible for the tobacco free credit providing you are tobacco free.

Note: If you work under the provisions of a collective bargaining agreement or are covered under a valid written customer contract, you are eligible to participate in this credit plan, if your current agreement specifically provides for this credit.

MEDICAL PLAN**Highlights of the UnitedHealthcare (UHC) Medical Plan Options****UHC Option 1 Plan Chart**

Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network*
<u>Annual Deductible</u>	\$750/ individual \$1,500/ employee +1 \$2,250/ family	\$1,500/ individual \$3,000/ employee +1 \$4,500/ family
<u>Prescription</u>	Not Included**	
<u>Coinsurance</u>	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Annual Out-of-Pocket Maximum</u>	\$5,400/ individual \$10,800/ family	\$10,000/ individual \$20,000/ family
<u>Physician Office Visit</u>		
Primary Care Specialist	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Virtual Visits</u>	Covered	Not Covered
<u>Cancer Services</u> Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. See <i>Cancer Resource Services (CRS)</i> Section	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<u>Clinical Trials</u> Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<u>Congenital Heart Disease (CHD) Surgeries</u> Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Preventive care</u> Includes colonoscopies, physician office services, lab X-ray or other preventive tests, breast pumps.	Plan pays 100% no annual deductible	Plan pays 60% after annual deductible

MEDICAL PLAN**UHC Option 1 Plan Chart, continued**
Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network*
<u>Inpatient and outpatient hospital services</u> Semi-private room and board, intensive care, cardiac care, well baby care	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Emergency room services</u> Includes all medically necessary treatment. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead. You must call your medical provider within 48 hours of your admission to a hospital	\$300 co-pay after annual deductible	\$300 co-pay after Network annual deductible
<u>Ambulance</u> For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare	Plan pays 80% after annual deductible	Plan pays 80% after Network annual deductible
<u>Urgent care center services</u> For conditions requiring immediate care when your doctor is not available or after normal hours	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Mental Health/Substance Use Disorder</u>	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Surgery</u>	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible*
<u>Allergy treatment</u> Injections, serum, and office visits	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Lab and X-ray services</u> Diagnostic** Diagnostic lab and x-ray services are subject to annual deductible and coinsurance	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Home health care</u> Limited to 40 days per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Skilled nursing facility/Inpatient rehabilitation</u> Confinement and skilled nursing services in a hospital or specialized facility Limited to 90 days per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Outpatient rehabilitation</u> Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type, network/non-network combined. Cardiac or pulmonary rehabilitation services, with no visit limit	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible

MEDICAL PLAN**UHC Option 1 Plan Chart, continued**
Claims Administrator UnitedHealthcare

<u>Plan Features</u>	<u>Network</u>	<u>Non-Network*</u>
<u>Chiropractic services</u> Spinal manipulation and modalities 35 visits per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Durable medical equipment</u> Splints, braces, non-surgically implanted prostheses, specified medical equipment for use in the home	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Hospice care</u> Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Maternity</u> Physician's office services, surgical and medical service fees, hospital inpatient/outpatient	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Infertility</u> Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Organ transplants</u> (Designated Provider must be used) Inpatient/outpatient surgery, and hospitalization Travel and lodging Unrelated bone marrow donor search	Plan pays 80% after annual deductible	Not Covered

** You must elect the Caremark Rx Plan in order to receive prescription benefits.

** Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of wellness exam.

MEDICAL PLAN

UHC HSA Plan Chart

Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network
Annual Deductible	\$1,400/ individual \$2,800/ employee +1 \$4,200/ family	\$2,800/ individual \$5,600/ employee +1 \$8,400/ family
Prescription	Included as part of Medical Plan. You pay the full cost of the prescription until you meet the deductible*	
Coinsurance	Plan pays 80% after annual deductible	Medicare Reimbursement Rate
Annual Out-of-Pocket Maximum	\$6,650/ individual \$13,300/ family	\$10,000/ individual \$20,000/ family
HSA Account: (Maximum amounts listed does not include Ryder contributions or incentives. You must deduct those amounts to ensure you do not exceed the maximum allowed.)	Employee can contribute up to \$3,450 for Employee only or \$6,900 for Family. \$1,000 additional if age 55 or older	
Physician office visit	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
Virtual Visits	Covered	Not covered
Cancer Services Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. See <i>Cancer Resource Services (CRS)</i> Section	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Clinical Trials Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Congenital Heart Disease (CHD) Surgeries Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
Preventive care Includes colonoscopies, physician office services, lab X-ray or other preventive tests, breast pumps.	Plan pays 100% no annual deductible	Plan pays 60% after annual deductible

MEDICAL PLAN

UHC HSA Plan Chart, continued
 Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network
<u>Inpatient and outpatient hospital services</u> Semi-private room and board, intensive care, cardiac care, well-baby care	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Emergency room services</u> Includes all medically necessary treatment. You must call your medical provider within 48 hours of your admission to a hospital	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Ambulance</u> For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare	Plan pays 80% after annual deductible	Plan pays 80% after Network annual deductible
<u>Urgent care</u>	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Mental Health/Substance Use Disorder</u>	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Surgery</u>	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Allergy treatment</u> Injections, serum, and office visits	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Lab and X-ray services</u> Diagnostic** Diagnostic lab and x-ray services are subject to annual deductible and coinsurance	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Home health care</u> Limited to 40 days per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Skilled nursing facility/Inpatient rehabilitation</u> Confinement and skilled nursing services in a hospital or specialized facility Limited to 90 days per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Outpatient rehabilitation</u> Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type, network/non-network combined. Cardiac or pulmonary rehabilitation services, with no visit limit	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Chiropractic services</u> Spinal manipulation and modalities 35 visits per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible

MEDICAL PLAN

UHC HSA Plan Chart, continued
Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network
<u>Durable medical equipment</u> Splints, braces, non-surgically implanted prostheses, specified medical equipment for use in the home	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Hospice care</u> Room and board in a licensed facility or home. Includes services of medical personnel and other services and supplies	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Maternity</u> Physician's office services, surgical and medical service fees, hospital inpatient/outpatient	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Infertility</u> Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered	Plan pays 80% after annual deductible	Plan pays 60% after annual deductible
<u>Organ transplants</u> Designated Provider must be used). Inpatient/outpatient surgery, and hospitalization, Travel and lodging Unrelated bone marrow donor search	Plan pays 80% after annual deductible	Not Covered

*Some drugs under the ACA are covered at 100%; chronic medications may bypass the deductible.

** Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of the wellness exam.

Opening a Health Savings Account (HSA)

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means for employees: When an employee opens an account, the employee will be asked to provide name, address, date of birth and other information that will allow the financial institution to identify the employee. Employees may also be asked to supply a copy of a driver's license or other identifying documents.

You may contribute on a pre-tax basis up to \$3,450 for single coverage or \$6,900 for employee +1 or family coverage annually. If you are 55 years of age or older, you can contribute an additional \$1000 annually. To help with funding your Health Savings Account, Ryder will contribute up to \$250 for single coverage and up to \$500 for employee +1 and Family coverage depending on your benefit effective date. Ryder will also fund \$100 in to your Health Savings Account if you (and your enrolled spouse/domestic partner) complete an annual preventive care physical exam.

If you choose to contribute to your HSA account, the minimum annual amount is \$100. When choosing your annual amount, you must deduct any Ryder contributions and incentives to make sure you don't go over the annual maximum allowed by the IRS.

Limits on Health Savings Account (HSA) Contributions

As a new hire there are rules around how much you can contribute into the HSA. You are responsible to manage contribution maximums allowed into the HSA:

MEDICAL PLAN

- If you are a new hire with a prior High Deductible Health Plan/HSA Enrollment, and you have continual 12-month enrollment, you may elect up to the maximum amount regardless of the benefit effective date.
- If you are a new hire with NO prior High Deductible Health Plan/HSA Enrollment, below is a guide of the amounts you may elect through payroll deductions for the rest of the calendar year.

It is possible to contribute up to the maximum annual limit for that year – even if you did not have eligibility for the full calendar year. However, the IRS requires that you maintain HSA eligibility through December 31 of the following year (this is referred to as the “testing period”). If you do not remain HSA-eligible through the testing period, income taxes plus a penalty may apply. For more information, consult your tax advisor.

Benefit Effective Date	Maximum Employee Annual Pre-Tax HSA Contribution – Single*	Maximum Employee Annual Pre-Tax HSA Contribution – Family*
January 1	\$3,450	\$6,900
February 1	\$3,157	\$6,325
March 1	\$2,870	\$5,750
April 1	\$2,583	\$5,175
May 1	\$2,296	\$4,600
June 1	\$2,009	\$4,025
July 1	\$1,722	\$3,450
August 1	\$1,435	\$2,875
September 1	\$1,148	\$2,300
October 1	\$ 861	\$1,725
November 1	\$ 574	\$1,150
December 1	\$ 287	\$ 575

*Less any contributions made to the HSA by Ryder or any earned incentives.

How Health Savings Account Funds Grow

The HSA is a true savings account. On balances of \$2,000 and up, you can choose to invest your savings in mutual funds for greater potential long-term growth (fees apply). Your HSA grows tax free. You can use your HSA dollars for current or future health care expenses.

MEDICAL PLAN**UHC Standard Plan Chart**

Claims Administrator UnitedHealthcare

Plan Features	In – Network ONLY*
<u>Annual Deductible</u>	\$2,600/ individual \$5,200/ employee +1 \$7,800/ family
<u>Prescription</u>	Included in Medical Plan, \$15 copay for generics. All other drugs you pay full cost until the deductible is met. Then coinsurance applies at 80%/20%**
<u>Coinsurance</u>	Plan pays 80% after annual deductible
<u>Annual Out-of-Pocket Maximum</u>	\$5,000/ individual \$10,000/ family
<u>Primary Care Physician office visit</u> <u>Specialist</u>	\$25 Plan pays 80% after annual deductible
<u>Virtual Visits</u>	Covered
<u>Cancer Services</u> Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. See Cancer Resource Services (CRS) Section	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<u>Clinical Trials</u> Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<u>Congenital Heart Disease (CHD) Surgeries</u> Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	Plan pays 80% after annual deductible
<u>Preventive care</u> Includes colonoscopies, physician office services, lab X-ray or other preventive tests, breast pumps.	Plan pays 100% no annual deductible
<u>Inpatient and outpatient hospital services</u> Semi-private room and board, intensive care, cardiac care, well-baby care	Plan pays 80% after annual deductible
<u>Emergency room services</u> Includes all medically necessary treatment. You must call your medical provider within 48 hours of your admission to a hospital	Plan pays 80% after annual deductible
<u>Ambulance</u> For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare	Plan pays 80% after annual deductible

MEDICAL PLAN**UHC Standard Plan Chart, continued**
Claims Administrator UnitedHealthcare

Plan Features	In – Network ONLY*
<u>Urgent care</u>	\$75 copay
<u>Mental Health/Substance Use Disorder</u>	Plan pays 80% after annual deductible
<u>Allergy treatment</u> Injections, serum, and office visits	Plan pays 80% after annual deductible
<u>Lab and X-ray services</u> Diagnostic*** Diagnostic lab and x-ray services are subject to annual deductible and coinsurance	Plan pays 80% after annual deductible
<u>Home health care</u> Limited to 40 days per calendar year	Plan pays 80% after annual deductible
<u>Skilled nursing facility/Inpatient rehabilitation</u> Confinement and skilled nursing services in a hospital or specialized facility. Limited to 90 days per calendar year.	Plan pays 80% after annual deductible
<u>Outpatient rehabilitation</u> Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type. Cardiac or pulmonary rehabilitation services, with no visit limit	Plan pays 80% after annual deductible
<u>Chiropractic services</u> Spinal manipulation and modalities. 35 visits per calendar year.	Plan pays 80% after annual deductible
<u>Durable medical equipment</u> Splints, braces, non-surgically implanted prostheses, specified medical equipment for use in the home	Plan pays 80% after annual deductible
<u>Hospice care</u> Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies	Plan pays 80% after annual deductible
<u>Maternity</u> Physician's office services, surgical and medical service fees, hospital inpatient/outpatient	Plan pays 80% after annual deductible
<u>Infertility</u> Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered	Plan pays 80% after annual deductible
<u>Organ transplants</u> (Designated Provider must be used) Inpatient/outpatient surgery and hospitalization, Travel and lodging, Unrelated bone marrow search	Plan pays 80% after annual deductible

*If you don't use network doctors and facilities, there is no reimbursement under the plan and claims will not be covered.

** Some drugs under the ACA are covered at 100%; chronic medications may bypass the deductible.

** Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of wellness exam.

MEDICAL PLAN

UHC Option 1 Passive PPO Chart
Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network
<u>Annual Deductible</u>	\$750/ individual \$1,500/ employee +1 \$2,250/ family	\$1,500/ individual \$3,000/ employee +1 \$4,500/ family
<u>Coinsurance</u>	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Annual Out-of-Pocket Maximum</u>	\$5,400/ individual \$10,800/ family	\$5,400/ individual \$10,800/ family
<u>Physician office visit</u>	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Virtual Visit</u>	Covered	Not Covered
<u>Cancer Services</u> Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. See Cancer Resource Services (CRS) Section	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<u>Clinical Trials</u> Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<u>Congenital Heart Disease (CHD) Surgeries</u> Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Preventive care</u> Includes colonoscopies, physician office services, lab X-ray or other preventive tests, breast pumps.	Plan pays 100% no annual deductible	Plan pays 100% no annual deductible
<u>Inpatient and outpatient hospital services</u> Semi-private room and board, intensive care, cardiac care, well baby care	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Emergency room services</u> Includes all medically necessary treatment. You must call your medical provider within 48 hours of your admission to a hospital	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible

MEDICAL PLAN**UHC Option 1 Passive PPO Chart, continued**

Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network
<u>Ambulance</u> For non-emergency use of ambulance, you must obtain prior approval from UnitedHealthcare	Plan pays 80% after annual deductible	Plan pays 80% after Network annual deductible
<u>Urgent care center services</u> For conditions requiring immediate care when your doctor is not available or after normal hours	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Mental Health/Substance Use Disorder</u>	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Surgery</u>	Plan pays 80% after annual deductible (90% if you use UHC Premium Cardiac Care Centers for cardiac surgery)	Plan pays 80% after annual deductible
<u>Allergy treatment</u> Injections, serum, and office visits	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Lab and X-ray services</u> Diagnostic* Diagnostic lab and x-ray services are subject to annual deductible and coinsurance	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Home health care</u> Limited to 40 days per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Skilled nursing facility/Inpatient rehabilitation</u> Confinement and skilled nursing services in a hospital or specialized facility Limited to 90 days per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Outpatient rehabilitation</u> Short-term physical, occupational, or speech therapy, limited to 35 visits per calendar year for each therapy type, network/non-network combined Cardiac or pulmonary rehabilitation services, with no visit limit	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Chiropractic services</u> Spinal manipulation and modalities 35 visits per calendar year, network/non-network combined	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Durable medical equipment</u> Splints, braces, non-surgically implanted prostheses, specified medical equipment for use in the home	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible

MEDICAL PLAN**UHC Option 1 Passive PPO Chart, continued**

Claims Administrator UnitedHealthcare

Plan Features	Network	Non-Network
<u>Hospice care</u> Room and board in a licensed facility or in your home. Includes services of medical personnel and other services and supplies	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Maternity</u> Physician's office services, surgical and medical service fees, hospital inpatient/outpatient	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Infertility</u> Diagnosis and treatment of the underlying condition. Any procedures done to promote pregnancy are not covered	Plan pays 80% after annual deductible	Plan pays 80% after annual deductible
<u>Organ transplants</u> Designated Provider must be used). Inpatient/outpatient surgery and hospitalization, Travel and lodging, Unrelated bone marrow search	Plan pays 80% after annual deductible	Not Covered

* Diagnostic laboratory and X-ray services performed during this visit are subject to the annual deductible and coinsurance unless part of wellness exam.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Definitions). The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

UnitedHealthcare Choice Plus Plans (UHC Option 1, UHC HSA, UHC Standard)

The Choice Plus Network is a group of healthcare providers that agree to provide services to participants at reduced costs.

- When you receive care from providers who are in the Choice Plus network, you receive the network level of benefits.
- When you see providers who are **not** a part of the Choice Plus Network, for Option 1 and HSA, the plan pays benefits up to 60% of Eligible Expenses Payable by the Plan after the annual deductible is met (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, "What the UnitedHealthcare Medical Plans Cover"). For the Standard Plan the plan pays nothing and you are responsible for the entire cost.
- Preventive care, such as well-baby and well-child checkups, immunizations, and routine physicals for adults and children are covered at 100% when network providers are used.
- Your physician may suggest you seek care from other physicians, specialists, and outpatient or inpatient facilities. It is your responsibility to determine if a provider participates in the plan in order to receive maximum benefits under the plan. A list of Choice Plus network providers in the UHC Plans is available by calling UnitedHealthcare Member Services at 888-899-4734 or online at www.uhc.com.

MEDICAL PLAN

UnitedHealthcare Option 1 Passive PPO Plan

The Option 1 Passive PPO Plan has a limited nationwide network of doctors, facilities and specialists. When you receive services from providers who are not a part of the network, you are provided coverage by a fee-for-service plan, which bases its reimbursement on reasonable and customary charges and pays benefits based on whether or not the service meets the definition of an Eligible Expense and whether or not it is a Covered Health Service. You and your dependents may receive care from any qualified licensed doctor, hospital or other health care facility.

- You will receive the same network level of benefits whether you choose a provider in the Choice Plus Network or outside of the network. However, when you receive care from providers who are not part of the UnitedHealthcare network, you do not have the advantage of the UnitedHealthcare network's negotiated rates.
- Preventive care, such as well-baby and well-child checkups, immunizations, and routine physicals for adults and children are covered at 100% whether a network provider is used or not.
- You are encouraged to use network providers when available, in order to receive maximum benefits under the plan. A list of Choice Plus network providers in the UHC Plans is available by calling UnitedHealthcare Member Services at 888-899-4734 or online at www.uhc.com.

How UnitedHealthcare Medical Plans Work

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply. You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits. You are responsible for determining whether or not your providers participate in UnitedHealthcare's network so that you are maximizing your benefits under the Medical Plan.

Network Benefits

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

When you use Network providers:

- You will pay UnitedHealthcare's negotiated rates for inpatient and outpatient network services until you reach your annual deductible. The annual deductible varies depending on the plan in which you are enrolled.
- Once you have met your annual deductible, the plan will pay 80% of network claims and you pay the remaining 20% of all covered claims. You continue to pay 20% of all covered claims until you reach your annual out-of-pocket maximum for the calendar year.
- After you meet your out-of-pocket maximum, the plan pays 100% of covered eligible expenses for the remainder of the calendar year.

Network providers are independent practitioners and are not employees of Ryder or UnitedHealthcare. It is your responsibility to select your provider.

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UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Non-Network Benefits

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

When you use Non-Network providers:

- You will pay 100% of your expenses until you reach the annual deductible (including preventive care). When you receive care from providers who are not part of the UnitedHealthcare Choice Plus network, you pay a higher deductible and you do not have the advantage of the UnitedHealthcare network's negotiated rates.
- After the annual deductible is met, for Option 1 and HSA the plan pays benefits up to 60% of Eligible Expenses Payable by the Plan (see definition of Eligible Expenses Payable by the plan in the section of this Book entitled, "What the UnitedHealthcare Medical Plans Cover").
- For the Standard Plan the plan pays nothing and you will be responsible for the entire claim.

Note: Services by non-network providers under the Option 1 Passive PPO Plan is covered on a different basis than the Choice Plus Options. The Option 1 Passive PPO Plan is the only plan where you are able to use non-network providers and pay the same deductible and coinsurance as if using a network provider. However, when you receive care from Non-Network providers, you do not have the advantage of UnitedHealthcare's negotiated rates. This plan is only available to employees that live in an area where the number of UnitedHealthcare network providers is limited. Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program at the end of the Medical Section of the SPD.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

If You Are Looking for a Network Provider

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

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UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com. Network providers are independent practitioners and are not employees of Ryder or UnitedHealthcare.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the selected Network Physician Covered Health Services will be paid at the non-Network level.

Eligible Expenses (applicable to the UHC Option 1, UHC HSA, UHC Standard Plans)

Ryder has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits (except the Standard Plan), Eligible Expenses are based on when Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion. If rates have not been negotiated:

- Eligible Expenses are determined based on 110 % of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of 50% of CMS for the same or similar laboratory service or 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
- When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and

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resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
- When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance-Related and Addictive Disorder services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a master's level counselor.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card

Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Eligible Expenses (applicable to the Option 1 Passive PPO Plan)

Ryder has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion. If rates have not been negotiated, then Eligible Expenses are

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determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception 50% of CMS for the same or similar laboratory service or 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

- When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a master's level counselor.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Annual Maximum

There is no annual maximum for Essential Benefits under the Ryder System, Inc. United Healthcare. Essential Health Benefits are health-related items and services that fall into the following categories, as defined in §1302 of health care reform law, and further determined by the Secretary of Health and Human Services: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under health care reform law, the Medical Plans have chosen the State of Florida as its benchmark state.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There is a combined Annual Deductible for Network and Non-Network Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

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Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you participate in UnitedHealthcare Option 1 Medical Plan and that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There is a combined Out-of-Pocket Maximum for Network Benefits and Non-Network Benefits. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided under your outpatient prescription drug plan.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization from UnitedHealthcare when required. Generally, if authorization from UnitedHealthcare is not obtained when required, Benefits will be reduced by 20% of Eligible Expenses.	No	No
Charges that exceed Eligible Expenses	No	No

Important Note: If Prior Authorization is not received, your benefits may be reduced by 20%. In such cases, any expense not paid by the plan will not count toward your Annual Deductible or Out-of-Pocket Maximum.

MEDICAL PLAN**Personal Health Support and Prior Authorization****Care Management**

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When UnitedHealthcare is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. Generally, if authorization from UnitedHealthcare is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

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If you are in the UHC Option 1, UHC HSA, UHC Standard Plans, in general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider and you are enrolled in the UHC Option 1 or UHC HSA Plans, you are responsible for obtaining prior authorization before you receive the services. Services for which prior authorization is required are identified in What the UnitedHealthcare Medical Plans Cover section of this Book within each Covered Health Service category. If you choose to receive Covered Health Services from a non-Network provider and you are enrolled in the UHC Standard Plan, you will be responsible for the entire cost of the services. If you are in the Option 1 Passive PPO Plan, UnitedHealthcare requires prior authorization for certain Covered Health Services. You are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, see What the UnitedHealthcare Medical Plans Cover section of this Book within each Covered Health Service category.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Network providers are generally responsible for obtaining prior authorization from UnitedHealthcare before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from UnitedHealthcare.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact UnitedHealthcare to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from UnitedHealthcare before you receive these services. In many cases, your Non-Network Benefits will be reduced if UnitedHealthcare has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in What the UnitedHealthcare Medical Plans Cover, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Important Note: If Prior Authorization is not received, your benefits may be reduced by 20%. In such cases, any expense not paid by the plan will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in the Coordination of Benefits (COB) section of this Book.

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What the UnitedHealthcare Medical Plans Cover

Eligible Expenses Payable by the Plan

For Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in [How UnitedHealthcare Medical Plans Work](#).

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in the UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Important Note: Any amount not reimbursed because you did not follow the recommendations of the claims administrator will not apply toward your annual deductible or your out-of-pocket maximums.

Covered Health Services

This section describes the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. Services that are not covered are described in the What the UnitedHealthcare Medical Plans Will Not Cover - Exclusions section of this Book.

Unless otherwise noted, benefits will be paid, after the annual deductible is met, at the percentage of network/non-network Eligible Expenses Payable by the Plan applicable to the UnitedHealthcare medical option in which you participate.

Acupuncture Services

Acupuncture services for pain therapy when the service is performed by a provider in the provider's office, when the provider is either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of:

- nausea of chemotherapy;
- post-operative nausea; and
- nausea of early pregnancy.

Ambulance Services

- **Emergency only**

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed. Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

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- **Non-Emergency**

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance as UnitedHealthcare determines appropriate) between facilities when the transport is:

From a non-Network Hospital to a Network Hospital.

- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain prior authorization from UnitedHealthcare as soon as possible prior to the transport. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Cancer Resource Services

The Plan pays Benefits for oncology services provided by Designated Provider participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Definitions.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under the applicable Covered Health Service category.

Note: The services described under *Travel and Lodging Assistance Program* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Chiropractic, Spinal Treatment and Osteopathic Manipulative Therapy

Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day. Up to 35 visits to a chiropractor are covered per calendar year, network/non-network combined.

Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other Physician for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

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Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are certain *Category B* devices, certain promising interventions for patients with terminal illnesses, other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI)).
 - Centers for Disease Control and Prevention (CDC).
 - Agency for Healthcare Research and Quality (AHRQ).
 - Centers for Medicare and Medicaid Services (CMS).
 - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

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- The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet the following criteria: Comparable to the system of peer review of studies and investigations used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement

You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses.

Congenital Heart Disease (CHD) Services

The Plan pays Benefits for Congenital Heart Disease (CHD) services when ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service, and are not an Experimental or Investigational Service or an Unproven Service. CHD services may be received at a Congenital Heart Disease Resource Services program.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at www.myoptumhealthcomplexmedical.com.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

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To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

There are specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about CHD services.

Note: The services described under Travel and Lodging are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits, you must obtain prior authorization from UnitedHealthcare as soon as the possibility of a congenital heart disease surgery arises. For Non-Network Benefits, if authorization from UnitedHealthcare is not obtained as required, Benefits for Covered Health Services will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits for Covered Health Services will be reduced by 20% of Eligible Expenses.

Dental Services

- Accident

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery, "D.D.S." or a Doctor of Medical Dentistry, "D.M.D."; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Benefits are available only for treatment of a sound, natural tooth.

The Physician or dentist must certify that the injured tooth was:

- a virgin or unrestored tooth; or
- a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage caused by accidental Injury must be both of the following:

- started within three months of the accident or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan; and
- completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

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Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

- Wisdom teeth, impacted only.

Diabetes Services

- **Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care**
Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
- **Diabetic Self-Management Items**
Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:
 - Insulin pumps that are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).
 - blood glucose meters including continuous glucose monitors;
 - insulin syringes with needles;
 - blood glucose and urine test strips;
 - ketone test strips and tablets; and
 - lancets and lancet devices.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization Requirement

If you are in the UHC Option 1 or UHC HSA, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use primarily in a home setting;
- used for medical purposes;
- not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment; and
- not of use to a person in the absence of a disease or disability;
- Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;

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Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks)

- delivery pumps for tube feedings;
- braces that stabilize an injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage;
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions; (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage);
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- Negative pressure wound therapy pumps (wound vacuums); and
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD.

UnitedHealthcare provides Benefits for a single unit of Durable Medical Equipment (example: one insulin pump) and provide repair for that unit.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits, you must obtain prior authorization from UnitedHealthcare before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If authorization from UnitedHealthcare is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item).

If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be reduced by 20% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network

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Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under Eligible Expenses.

Note: If you are in the Option 1 Passive PPO Plan, and are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 48 hours or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. And if you are admitted to a Hospital as a result of an Emergency, you must notify the Claims Administrator as soon as is reasonably possible.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when Skilled Care is required.

UnitedHealthcare will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits, you must obtain prior authorization from UnitedHealthcare five business days before receiving services including nutritional foods and Private Duty Nursing or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from the Claims Administrator five business days before receiving services including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses.

Up to 40 visits are covered per calendar year, network/non-network combined.

Hospice Care

The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits, you must obtain prior authorization from UnitedHealthcare five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If authorization from UnitedHealthcare is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from UnitedHealthcare five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably

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possible. If authorization from UnitedHealthcare is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for,

- A scheduled admission: you must obtain prior authorization five business days before admission;
- A non-scheduled admission (including Emergency admissions): you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, for:

- A scheduled admission: you must obtain prior authorization five business days before admission;
- A non-scheduled admission (including Emergency admissions): you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses.

Kidney Resource Services (KRS)

These Benefits are for Covered Health Services provided through KRS only. The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Providers participating in the Kidney Resource Services (KRS) program.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by the Claims Administrator or Personal Health Support or
- call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. The term Designated Provider is defined at the end of the Medical section of this Book.

If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health

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Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; and
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits you must obtain prior authorization from UnitedHealthcare as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, benefits for the extended stay will be reduced by 20% of Eligible Expenses.

If you are in the If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from UnitedHealthcare as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits for the extended stay will be reduced by 20% of Eligible Expenses.

Mental Health Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment
- Residential Treatment
- Partial Hospitalization/Day Treatment
- Intensive Outpatient Treatment
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning
- Treatment and/or procedures

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- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

The Plan also pays Benefits for behavioral services for Autism Spectrum Disorder (otherwise known as neurobiological disorders) that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

The Mental Health/Substance-Use Disorder Administrator provides administrative services for all levels of care. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; applied behavior Analysis, extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced by 20% of Eligible Expenses.

Bariatric Resource Services (BRS)

Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurse help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide

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information on the nation's leading obesity surgery centers, known as Centers of Excellence. Access the Bariatric Resource Services Centers of Excellence program at **(888) 936-7246**.

All authorization information and enrollment for bariatric surgery must be initiated through OptumHealth's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should notify OptumHealth as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth at **(888) 936-7246** to enroll in the program.

Obesity Surgery

The Plan covers surgical treatment of morbid obesity provided by or under the direction of a Physician providing either of the criteria is met:

- you are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4;
- you have a minimum Body Mass Index (BMI) of 40, or ≥ 35 with at least 1 co-morbid condition present (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.
- you must enroll in the OptumHealth Bariatric Resource Services (BRS) program;
- you must use an OptumHealth Bariatric Center of Excellence (COE);
- you have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation;
- 6-month physician supervised diet documented within the last 2 years;
- One surgery per lifetime unless complications;
- Excess skin remove is NOT covered, unless medically necessary.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, and are not Experimental or Investigational or Unproven Services.

Note: The services described under Travel and Lodging are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits you must obtain prior authorization from UnitedHealthcare as soon as the possibility of obesity surgery arises.

If you fail to obtain prior authorization from UnitedHealthcare as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from UnitedHealthcare as soon as the possibility of obesity surgery arises.

If you fail to obtain prior authorization from UnitedHealthcare as required, Benefits will be reduced by 20% of Eligible Expenses.

It is important that you provide notification regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Orthognathic Surgery

Orthognathic surgery (procedure to correct underbite or overbite) including diagnosis and treatment of the jawbone is covered. In addition, surgical exposure or removal of impacted wisdom teeth, including related X-ray, and osseous surgery (tissue and bone grafting) is covered.

Orthotics

The following orthotics are covered: Shoe/Shoe Orthotics/Shoe Inserts/Arch Supports, prescribed by physician; and Cranial Orthotics (Helmets) custom molded, prescribed by physician. No other orthotics are covered.

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Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for blepharoplasty, uvulopalatopharyngoplasty, vein procedures, and sleep apnea surgeries, cochlear implant and orthognathic surgeries you must obtain prior authorization from UnitedHealthcare five business days before scheduled services are received or for non-scheduled services, within 48 hours or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, for blepharoplasty, uvulopalatopharyngoplasty, vein procedures, and sleep apnea surgeries, cochlear implant and orthognathic surgeries you must obtain prior authorization from UnitedHealthcare five business days before scheduled services are received or for non-scheduled services, within 48 hours or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses.

Outpatient Diagnostic Services

The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: Lab and radiology/X-ray and Mammography testing. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services. Lab, X-ray and diagnostic services for preventive care are described under Preventive Care Services in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient in this section.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for sleep studies, you must obtain prior authorization from UnitedHealthcare five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan for sleep studies, you must obtain prior authorization from UnitedHealthcare five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced by 20% of Eligible Expenses.

This section does not include Benefits for CT scans, PET scans, MRIs, MRA's, nuclear medicine and major diagnostic services, which are described immediately below.

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- Outpatient Diagnostic/Therapeutic Services – CT Scans, PET Scans, MRI, MRA, Nuclear Medicine and major diagnostic services

The Plan pays for Covered Health Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Outpatient Therapeutic Services

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis* (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy, and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

*Note: Out of network dialysis services are not covered. To receive benefits related to dialysis services, you must use a UnitedHealthcare in-network provider and facility. If you receive dialysis services from an out-of-network provider or facility, those services are not eligible plan expenses and you will be responsible for 100% of the cost for those out-of-network dialysis services. It is best to contact a Member Services representative (using the toll-free number on your membership ID card) to verify in-network service providers before beginning dialysis treatment.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization from UnitedHealthcare five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, radiation oncology, intensity modulated radiation therapy and MRI-guided focused ultrasound. If you fail to obtain prior authorization from UnitedHealthcare, as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, for the following outpatient therapeutic services you must obtain prior authorization from UnitedHealthcare five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MRI-guided focused ultrasound. If you fail to obtain prior authorization from UnitedHealthcare, as required, Benefits will be reduced by 20% of Eligible Expenses.

Physician's Office Services - Sickness and Injury; Injections received in a Physician's Office

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of

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whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under Preventive Care Services in this section.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits, you must obtain prior authorization from UnitedHealthcare as soon as is reasonably possible before Genetic Testing – BRCA is performed. If authorization is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from UnitedHealthcare as soon as is reasonably possible before Genetic Testing – BRCA is performed. If authorization is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses.

Note: Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pharmaceutical Products – Outpatient

The plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's Office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Unitedhealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year. This exclusion may not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment).

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Covered Health Services. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.). Any combination of Network Benefits and Non-Network Benefits is limited to \$50,000 per lifetime.

Physicians Fees for Surgical and Medical Services

The Plan pays for **Physicians** fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands;
- Artificial face, eyes, ears and noses;
- breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

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Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Note: Prosthetic devices are different from DME - see Durable Medical Equipment (DME) in this section.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits you must obtain prior authorization from UnitedHealthcare before obtaining prosthetic devices that exceed \$1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, you must obtain prior authorization from UnitedHealthcare before obtaining prosthetic devices that exceed \$1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced by 20% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is to either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedures. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedures.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for a scheduled Reconstructive Procedure, you must obtain prior authorization from UnitedHealthcare five business days before a scheduled Reconstructive Procedures is performed. For a non-scheduled Reconstructive Procedure you must provide notification within one business day or as soon as is reasonably possible. If authorization is not obtained from UnitedHealthcare as required, or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, for a scheduled Reconstructive Procedure, you must obtain prior authorization from UnitedHealthcare five business days before a scheduled Reconstructive Procedure is performed. For a non-scheduled Reconstructive Procedure you must provide notification within one business day or as soon as is reasonably possible. If authorization is not obtained from UnitedHealthcare as required, or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for:

- physical therapy;
- occupational therapy;
- speech therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline;
- It is ordered by a Physician and provided and administered by a licensed provider;
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively;
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

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The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated. Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under Durable Medical Equipment and Prosthetic Devices.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

Benefits are limited to:

- 35 visits per calendar year for physical therapy;
- 35 visits per calendar year for occupational therapy;
- 35 visits per calendar year for speech therapy;
- No visit limit per calendar year for pulmonary rehabilitation therapy; and
- No visits limit per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay;
- Room and board in a Semi-private Room (a room with two or more beds);
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- It is ordered by a Physician;
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively;
- You are expected to improve to a predictable level of recovery.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined.

MEDICAL PLAN**Prior Authorization Requirement**

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission. For a non-scheduled admission (or admissions resulting from an Emergency), you must provide notification as soon as is reasonably possible. If authorization is not obtained as required or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, for a scheduled admission, you must obtain prior authorization five business days before admission. For a non-scheduled admission (or admissions resulting from an Emergency), you must provide notification as soon as reasonably possible. If authorization is not obtained as required or notification is not provided, Benefits will be reduced by 20% of Eligible Expenses.

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment;
- Residential Treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning;
- Treatment and/or procedures;
- Medication management and other associated treatments;
- Individual, family and group therapy;
- Provider-based case management services;
- Crisis intervention.

The Mental Health/Substance Use Disorder Administrator provides administrative services for all levels of care. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

If you are in the UHC Option 1, UHC HSA, for Non-Network Benefits for a scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility) you must obtain authorization from UnitedHealthcare five business days before admission. For a non-scheduled admission (including Emergency admissions) you must provide notification as soon as reasonably possible. In addition, for Non-Network Benefits you must obtain prior authorization from UnitedHealthcare before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. If you fail to obtain prior authorization from or provide notification to UnitedHealthcare as required, Benefits will be reduced by 20% of Eligible Expenses.

If you are in the Option 1 Passive PPO Plan, for a scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from UnitedHealthcare five business days before admission. For a non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible. In addition, you must obtain prior authorization from UnitedHealthcare before the following services are received.

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Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. If you fail to obtain prior authorization from or provide notification to UnitedHealthcare as required, Benefits will be reduced by 20% of Eligible Expenses.

Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service. Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan. The Claims Administrator has specific guidelines regarding Benefits for transplant services. Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received at a Designated Provider.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under Travel and Lodging are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement

You must obtain prior authorization from UnitedHealthcare as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed by a Designated Provider, you will be responsible for paying all charges and no Benefits will be paid.

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts. If you have questions regarding Travel and Lodging, contact the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion;
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered;
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider;

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- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

A per diem rate, up to \$50.00 per day, for the patient or the caregiver if the patient is in the Hospital.

A per diem rate, up to \$100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries;
- Alcoholic beverages;
- Personal or cleaning supplies;
- Meals;
- Over-the-counter dressings or medical supplies;
- Deposits;
- Utilities and furniture rental, when billed separate from the rent payment;
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider;
- Taxi fares (not including limos or car services);
- Economy or coach airfare;
- Parking;
- Trains;
- Boat;
- Bus;
- Tolls.

Urgent Care Center Services

The Plan pays for Covered Health Services received at an Urgent Care Center. When Urgent Care services are provided in a Physician's office, Benefits are available as described under Physician's Office Services earlier in this section.

Clinical Programs and Resources

You have several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

Note: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Ryder are not responsible for the results of your decisions from the use of the information, including, but not limited to; your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the information.

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Consumer Solutions and Self-Service Tools

Health Assessment

You and your covered Spouse/Domestic Partner are invited to learn more about your health and wellness at **myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks. Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **myuhc.com**. After logging in, access your personalized Health & Wellness page and click the Health Assessment link.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise,
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Ryder's way of helping you meet your health and wellness goals.

Real Appeal

Real Appeal is an online weight loss and healthy lifestyle program that can help you take small steps that lead to big results. If you've been struggling to lose weight, Real Appeal's personalized approach can help. By implementing small changes over time, you'll gradually shift to a healthier, happier lifestyle and begin to see results that last. If your spouse/domestic partner are enrolled in one of the UnitedHealthcare Medical plans and you meet the requirement of a body mass index (BMI) of 25 or higher, you may be eligible to join Real Appeal at no cost.

Once you enroll, you will meet with a Transformation Coach – right from your smart phone, tablet or personal computer – who customizes a program that suits your lifestyle and targets your desired weight loss goals. Note: it will not be possible to participate in the program using a Ryder issued computer, as the security firewall and bandwidth space will limit or deny user access. Accordingly, you must use your smart phone, tablet, or home computer to take part in the program. You will receive 52 weeks of access to this coach who will offer continual support and help you stay on track. After your goals are set and your coaching support network is intact, you will receive the Real Appeal Success Kit delivered to your door at no cost. The kit comes with nutrition and activity guides, workout DVDs, digital food scale, resistance bands and electronic body weight scale.

In addition, Real Appeal offers a complete online experience to keep you motivated and inspired. You'll receive unlimited access to digital content like streaming workout videos and the Real Appeal All Star Show featuring tip and tricks from celebrities, athletes and health experts. You'll also have access to online tools to track diet, activity and weight loss progress and a Real Appeal Success Group to connect with other people in the program. There's also a Real Appeal mobile app so you can access these tools anytime, anywhere. To sign up for the Real Appeal program go to ryder.realappeal.com.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log into myuhc.com or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. [myuhc.com](http://www.myuhc.com) opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With [myuhc.com](http://www.myuhc.com) you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

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Registering on myuhc.com

If you have not already registered as a **myuhc.com** subscriber, simply go to **myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Coinsurance and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

To learn more about a condition or treatment, log on to **myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Virtual Visits

Those enrolled in any of the UnitedHealthcare Medical Plans, have access to a doctor via Virtual Visits by logging into www.myuhc.com and choosing from provider sites and registering for a virtual visit. A virtual visit allows you to see and talk to a doctor from any mobile device or computer without an appointment. Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary. Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at 866-936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see What the UnitedHealthcare Medical Plans Cover section of this Book under the heading Cancer Resource Services (CRS).

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is available for Covered Persons living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP program. If you think you may be eligible to participate or would like additional information regarding the programs, please call the number on your ID card.

HealthNotesSM

UnitedHealthcare provides a service called HealthNotes to help educate members and make suggestions regarding your medical care. HealthNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealthNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine.

If your Physician identifies any concerns after reviewing his or her HealthNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs**Healthy Pregnancy Program**

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life[®] program employs an evidence-based combination of physical,

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psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions;
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat;
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date;
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching;
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity;
- Tailored motivational emails sent throughout your quitting process;
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, call the number on the back of your ID card.

What the UnitedHealthcare Medical Plans Will Not Cover (Exclusions)

This section includes services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in What the UnitedHealthcare Medical Plans Cover section of this Book.

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

Also, please review all limits described in the What the UnitedHealthcare Medical Plans Cover section of this Book carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Alternative Treatments

- acupuncture;
- aromatherapy;
- hypnotism;
- massage therapy;
- rolfing;
- other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
- services received by a naturopath;
- holistic or homeopathic care.

Comfort or Convenience

- television;
- telephone;
- beauty/barber service;
- guest service;
- supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filter, batteries and battery chargers, dehumidifiers, humidifiers, devices and computers to assist in communication and speech, home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

Dental

- dental care, except as described in What the UnitedHealthcare Medical Plans Cover section of this Book under the heading Dental Services;
 - preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following: extraction, restoration and replacement of teeth, medical or surgical treatments of dental conditions, services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details.
- dental implants;
- dental braces;
- dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; however, this exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in What the UnitedHealthcare Medical Plans Cover section of this Book;
- treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

- Devices used specifically as safety items or to affect performance in sports-related activities;
- Orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME). Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease;
- The following items are excluded, even if prescribed by a Physician: Blood pressure cuff/monitor, Enuresis alarm, Non-wearable external defibrillator, Trusses, Ultrasonic nebulizers;
- Repairs to prosthetic devices due to misuse, malicious damage or gross neglect;
- Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items;
- Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment;
- Oral appliances for snoring.

Drugs (Refer to the Prescription Plan Section)

- prescription drug products for outpatient use that are filled by a prescription order or refill;
- self-injectable medications;
- non-injectable medications given in a Physician's office except as required in an Emergency;
- over the counter drugs and treatments.

Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials.

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Foot Care

- hygienic and preventive maintenance foot care. Examples include the following:
 - cleaning and soaking the feet;
 - applying skin creams in order to maintain skin tone;
 - other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
- treatment of flat feet;
- treatment of subluxation of the foot.

Medical Supplies

- prescribed or non-prescribed medical supplies. Examples include:
 - compression stockings;
 - ace bandages;
 - gauze and dressings;

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment;
- Diabetic supplies for which Benefits are provided as described under Diabetes Services;
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies.
- orthotic appliances other than foot orthotics and cranial banding as described under Durable Medical Equipment (DME);
- tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment as described in What the UnitedHealthcare Medical Plans Cover section of this Book under the heading Durable Medical Equipment;
- The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;
- The replacement of lost or stolen Durable Medical Equipment.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance Use Disorder Services

In addition to all other exclusions listed in this Section, the exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance Use Disorder Services, Additional Coverage Details.

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder;
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act;
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders;
- Transitional Living services.

Nutrition

- megavitamin and nutrition based therapy;
- nutritional counseling for either individuals or groups , including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment;
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
- weight loss programs, health clubs and spa programs;
- food of any kind. Foods that are not covered include:
 - enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
 - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
 - oral vitamins and minerals;
 - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
 - other dietary and electrolyte supplements.

Physical Appearance

- Cosmetic Procedures. Examples include:
 - pharmacological regimens, nutritional procedures or treatments;
 - scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - skin abrasion procedures performed as a treatment for acne;
- replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in What the UnitedHealthcare Medical Plans Cover section of this Book;
- physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation;
- weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded;
- wigs regardless of the reason for the hair loss;
- services received from a personal trainer;
- liposuction.

Providers

- services performed by a provider who is a family member by birth or marriage, including Spouse/Domestic Partner, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
- services performed by a provider with your same legal residence;
- services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee

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or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

- has not been actively involved in your medical care prior to ordering the service; or
- is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

- health services and associated expenses for infertility treatments, including IVI & IVF, GIFT, ZIFT;
- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

- surrogate parenting; donor eggs, donor sperm and host uterus;
- the reversal of voluntary sterilization;
- fees or direct payment to a donor for sperm or ovum donations;
- Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
- health services and associated expenses for elective abortion;
- fetal reduction surgery;
- health services associated with the use of non-surgical or drug-induced Pregnancy termination.

Transplants

- health services for organ, multiple organ and tissue transplants, except as described in Transplantation Services in What the UnitedHealthcare Medical Plans Cover section of this Book, unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
- health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.);
- health services for transplants involving permanent mechanical or animal organs;
- transplant services that are not performed at a Designated Provider as defined in the Definitions section of this book. (This exclusion does not apply to cornea transplants.)

Travel

- health services provided in a foreign country, unless required as Emergency Health Services;
- travel or transportation expenses, even though prescribed by a Physician except as identified under Travel and Lodging. Additional travel expenses related to covered services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services.

Vision and Hearing

- implantable lenses used only to correct a refractive error (such as Intacs Corneal Implants);
- purchase cost and associated fitting charges for eyeglasses or contact lenses, except for the first set of contact lenses and/or eyeglasses needed due to surgery which removes the natural lens;
- eye exercise or vision therapy other than as a treatment for strabismus (misalignment of the eyes);
- surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy;
- hearing aids or examinations for their prescription or fitting, except for one aid or one pair per lifetime; this is a one-time benefit limited to \$1,000 maximum (batteries are not covered);
- bone anchored hearing aids except when either of the following applies:

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- for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

All Other Exclusions (this list is not intended to be all-inclusive)

1. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following: Medically Necessary, Described as a Covered Health Service in this SPD, Not otherwise excluded in this SPD under Exclusions.
2. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
 - related to judicial or administrative proceedings or orders;
 - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials;
 - required to obtain or maintain a license of any type;
3. health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
4. charges for any injury, condition, illness or disease incurred as a result of any accident involving an automobile, boat, plane, dirt bike, motorcycle, bicycle, bus, or other vehicle. Benefits may be deemed eligible once complete accident details are received by the plan and you agree to the subrogation provision of the plan;
5. charges for any illness or injury for which expenses were incurred, services received, or treatment given before the effective date of coverage;
6. health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;
7. health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
8. in the event that a Non-Network provider waives Coinsurance and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Coinsurance and/or the Annual Deductible are waived;
9. charges in excess of Eligible Expenses or in excess of any specified limitation;
10. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;
11. non-surgical treatment of obesity, including morbid obesity;
12. surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 40) except for Class III obesity;
13. growth hormone therapy;
14. sex transformation operations and related services.;
16. custodial Care or maintenance care;
17. domiciliary Care;
18. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
19. Private Duty Nursing - Inpatient;

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20. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in What the UnitedHealthcare Medical Plans Cover section of this Book;
21. rest cures;
22. psychosurgery;
23. treatment of benign gynecomastia (abnormal breast enlargement in males);
24. medical and surgical treatment of excessive sweating (hyperhidrosis);
25. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
26. appliances for snoring;
27. marriage counseling;
28. smoking cessation programs, other than the Quit For Life[®] program;
29. any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;
30. any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment;
31. any charge for services, supplies or equipment advertised by the provider as free;
32. any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency;
33. any charges prohibited by federal anti-kickback or self-referral statutes;
34. services resulting from the commission of a felony;
35. treatment or services when confined in a prison, jail, or other penal institution;
36. examinations or treatment ordered by a court in connection with legal proceedings;
37. items, which have value to the participant in the absence of an illness or injury being treated;
38. chelation therapy, except to treat heavy metal poisoning;
39. any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services;
40. outpatient rehabilitation services, spinal treatment, manipulative treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring;
41. spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies;
42. speech therapy to treat stuttering, stammering, or other articulation disorders;
43. breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in What the UnitedHealthcare Medical Plans Cover section of this Book;
44. foreign language and sign language services;
45. panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to Reconstruction - Post-Mastectomy in What the UnitedHealthcare Medical Plans Cover section of this Book;
46. insulin;
47. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Claims Procedures

See the Administrative Information section of this Summary Plan Description Book for specific procedures regarding medical claims.

Coordination of Benefits (COB)

The Coordination of Benefits (COB) rules applies if you or your enrolled dependents are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, the COB process determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Update your Dependents' Other Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's other medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse/Domestic Partner of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse/Domestic Partner of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; The expenses must be covered in part under at least one of the plans; and

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- if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) You and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You visit a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse/Domestic Partner's plan, this Plan will pay Benefits for the Physician's office visit first.

2) If you and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You take your Dependent child to visit a Physician. This Plan will look at your birthday and your Spouse/Domestic Partner's birthday to determine which plan pays first. If you were born on June 11 and your Spouse/Domestic Partner was born on May 30, your Spouse/Domestic Partner's plan will pay first.

Example		
<i>Birthdate:</i>	<i>Mother: May 30</i>	<i>Father: June 11</i>
<i>Mother's Plan is Primary</i>		

3) You and your Spouse/Domestic Partner both have family medical coverage through your respective employers. You take your Dependent child to visit a Physician. This Plan will look at your birthday and your Spouse/Domestic Partner's birthday to determine which plan pays first. If both parents have the same birthday, the plan that covered one parent longer will be primary.

Example		
<i>Birthdate:</i>	<i>Mother: March 10</i>	<i>Father: March 10</i>
<i>Benefit Effective Date:</i>	<i>Mother: Feb. 1, 2015</i>	<i>Father: Feb 1, 2012</i>
<i>Father's Plan is Primary</i>		

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense;
- If this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits;
- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan Is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable

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expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare**Determining Which Plan Is Primary**

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses/Domestic Partners age 65 or older;
- individuals with end-stage renal disease, for a limited period of time;
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience [UnitedHealthcare, the Claims Administrator] will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

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Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan. You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) expenses, under Part B (Physician office visits), and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses. If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, from the provider pursuant to Refund of Overpayments, below.

COB and Benefit Claims

To avoid delays in processing your claim when non-duplication applies, file claims with the primary plan first.

Important Note: When you receive an explanation of benefits (EOB) from the primary plan, submit the claim to the secondary plan with a copy of the itemized bill and a copy of the EOB. The secondary plan needs this information to process your claim.

If the plan pays more than it should when another plan is involved, it will request a repayment of benefits from the other plan or from you.

Refund of Overpayments

If Ryder pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Ryder if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- All or some of the payment the Plan made exceeded the Benefits under the Plan;
- All or some of the payment was made in error.

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The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

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

Subrogation – Example

You are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and the driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

You are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- The Plan Sponsor in a workers' compensation case or other matter alleging liability;
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto

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insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators;

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

You agree as follows:

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

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

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

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

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- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were made in error, due to a mistake in fact, advanced during the time period of meeting the calendar year deductible, or advanced during the time period of meeting the out-of-pocket maximum for the calendar year. Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will require that the overpayment be returned when requested and reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the plan or conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

UHC Medical Definitions

Accident: for the purposes of the Medical Plan, a sudden unexpected occurrence traceable within reasonable limits to a defined time, plan and cause.

Autism Spectrum Disorders: a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Cancer Resource Services (CRS): a program administered by UnitedHealthcare or its affiliates. The CRS program provides:

- specialized consulting services, on a limited basis, to you and your eligible dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Claims Administrator: UnitedHealthcare (also known as United HealthCare Services, Inc) and its affiliates, who provide certain claim administration services for the Plan.

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Covered Health Services: those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary
- Described as a Covered Health Service in this SPD under Plan Highlights and How the UnitedHealthcare Medical Plans Work
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility
- Not otherwise excluded in this SPD under Exclusions.

Designated Facility: A facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the plan to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

Designated Provider: a provider and/or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures. A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

Eligible Expenses: for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.
- **Emergency Health Services:** with respect to an Emergency, both of the following: A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Experimental or Investigational Services: medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

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- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions - If you have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Home Health Care Agency: an organization that has been licensed or certified as a home health care agency in a state where home health care is given, or is a home health care agency as defined by Medicare and has been approved by the benefits administrator.

Hospice: a facility that provides short periods of stay for a terminally ill person in a homelike setting for either direct care or respite care. This facility may be either freestanding or affiliated with a hospital.

Hospital: an institution that meets one of the following tests:

- it is accredited as a hospital by the American Osteopathic Association; the Commission on the Accreditation of Rehabilitative Facilities; or the Hospital Accreditation Program of the Joint Commission on the Accreditation of Healthcare Organizations.
- it is legally operated, has 24-hour-a-day supervision by a staff of doctors, has 24-hour-a-day nursing service by registered graduate nurses, and complies with either of the following: it mainly provides general in-patient medical care and treatment of sick and injured persons by the use of medical, diagnostic and major surgical facilities. All such facilities are under its control;
- it mainly provides specialized in-patient medical care and treatment of sick or injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All such facilities are in it, under its control, or available to it under written agreement with a hospital (as defined above) or with a specialized provider of those facilities;
- it is licensed, certified or approved as a freestanding surgical facility by the appropriate agency of the state in which it is located; the State Department of Health licenses it as a birth center.

A hospital *is not* a nursing home, institution, or part of one, which:

- is used mainly as a place for convalescence, rest, nursing care or care for the aged;
- furnishes mainly homelike (custodial) care or training in the routines of daily living; or
- is mainly a school.

Intensive Behavioral Therapy (IBT): outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include Applied Behavior Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI).

Medically Necessary: health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.

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- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

New Pharmaceutical Product: a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates:

The date as determined by the Claims Administrator or the Claims Administrator's designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented; or December 31st of the following calendar year.

Pharmaceutical Product(s): U.S. Food and Drug Administration (FDA)-approved prescription medications, products or devices administered in connection with a Covered Health Service by a Physician.

Residential Treatment: treatment in a facility which provides Mental Health Services or Substance Use Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu: Room and board, Evaluation and diagnosis, Counseling.
- Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Shared Savings Program: a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your

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ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Transitional Living: Mental Health Services/Substance Use Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

PRESCRIPTION PLAN

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

PRESCRIPTION PLAN

Introduction

This section provides you with information about the Ryder System, Inc. Prescription Plan. You must elect Medical Plan coverage in order to elect coverage under the Prescription Plan. Your coverage category for the Prescription Plan can be no greater than your coverage category for the Medical Plan. You cannot enroll dependents in Prescription Plan coverage if they are not enrolled in Medical Plan coverage. However, you may elect not to enroll a Dependent in Prescription Plan coverage if they are enrolled in Medical Plan coverage. For example, you may elect Family coverage for your Medical Plan and Employee + Spouse for the Prescription Plan.

Prescription Plan

The program is a managed prescription drug plan that provides prescription drug coverage to you through a national network of participating pharmacies.

To use the program, you may purchase up to a 30-day supply of medication at a participating retail pharmacy by presenting your Prescription Program ID card and the physician's original prescription. You will be required to pay either a copay or coinsurance depending on whether you purchase brand name or generic drugs. If you use a participating pharmacy, no paperwork or claim forms are necessary.

Long-term, maintenance medications must be obtained through the 90-day Mail Service Program or a CVS Pharmacy. The Mail Service Program or the option of CVS Pharmacy provides you with two convenient and cost-effective ways to purchase up to a 90-day supply of maintenance medication. Maintenance medications include those prescription drugs you take on an ongoing basis for conditions such as diabetes, ulcers, arthritis or heart disease. If a member continues to fill a maintenance medication at a non-CVS retail store after their second fill or if a member does not fill a prescription with a 90-day supply at a CVS retail store, a penalty will apply.

The Prescription Plan, either at the retail pharmacy or through the Mail Services Program, requires the use of generic drugs when they are available. Many, but not all drugs are available in a generic form. Prescriptions that are available as generic have two names, the trademark or brand name, and the chemical or generic name. By law, both brand name and generic drugs must meet the same standards for safety, purity, strength and quality. All prescriptions are filled with the generic version when available.

If you wish to have the brand name drug rather than the generic equivalent, the plan allows for the substitution, however, your cost for the drug is higher. If you choose a brand name medication, you will be responsible for the brand copay (or coinsurance if applicable) plus the cost difference between the brand name and generic drug, even if dispensed as written (DAW) is indicated on the prescription. If a generic drug is not available, you pay either the brand/Preferred Drug List or the brand/Non-Preferred Drug List copay (or coinsurance if applicable) for the prescription.

Variations in Coverage

The Prescription Plan is designed to cover all Company employees nationwide; however, because of certain state laws and plan designs, there are some variations in coverage for employees in certain locations.

If you are covered by one of the following Medical Plans: Blue Care Network, Humana (PR) or Kaiser (CA, GA, HI, OR, Mid-Atlantic region), you are **not** eligible for the prescription program through the Ryder Prescription Plan. Your prescription coverage is provided by your Medical Plan.

PRESCRIPTION PLAN**Highlights of the Prescription Plans**

Administered by Caremark Prescription Services - Most pharmacy chains and independent pharmacies participate in the retail network. For a list of pharmacies in your area, you can use the Caremark Pharmacy Locator on their website, www.caremark.com or call customer service at 800-421-5501.

	Retail Program Must use network pharmacy Limited to a 30-day supply	Mail Service Program Or CVS Retail Store Limited to a 90-day supply
Annual Deductible	\$100 – does not apply to generics or to the HSA Medical Plan	
Generic Co-Pay	\$10 co-pay	\$25 co-pay
Preferred Drug List – Brand Name Coinsurance*	You pay 25% after annual deductible (\$25 minimum-\$100 maximum)	You pay 25% after annual deductible (\$62.50 minimum-\$250.00 maximum)
Non-Preferred Drug List – Brand Name Co-insurance**	You pay 45% after annual deductible (\$50 minimum-\$150 maximum)	You pay 45% after annual deductible (\$125 minimum-\$375 maximum)
Biotech Medication	\$125 co-pay after annual deductible 30-day supply subject to pre-authorization	
If enrolled in Option 1 Medical Plan, you have an out-of-pocket maximum on prescription spend.	\$1,750 single / \$3,500 Family	

* If a generic medication is available and you elect to fill the prescription with a brand name medication, you will pay the brand name co-insurance plus the cost difference between the brand name and the generic medications even if Dispensed as Written is indicated on the prescription.

Brands and Generics

Brand name drugs are drugs protected by a patent and manufactured by a specific Company. Generic drugs are manufactured according to the same chemical formula of the brand name drugs whose patents have expired. Generic drugs usually cost less. The Food and Drug Administration requires that generic drugs have the same active chemical composition, have the same potency, and be offered in the same dosage form as their brand name counterparts.

The fundamental difference between a brand name and a generic equivalent is the manufacturer and price.

Preferred Drug List Medications

When there is no generic medication available, there may be more than one brand name drug to treat your condition. The brand name medications approved by the plan and on the Preferred Drug List have been selected by Caremark's National Pharmacy and Therapeutics Committee for their ability to meet the patient's needs with the best possible outcomes.

Ask your doctor to consider prescribing a brand name from your Caremark Preferred Drug List when there is more than one brand name drug available to treat your condition.

PRESCRIPTION PLAN

Biotech Specialty Medications

Biologic/Biotech medications include a wide variety of products derived from human, animal, or microorganisms by using biotechnology. They frequently are administered as injectables. It is also becoming more common that they can be taken orally as well. They are used to treat rare or chronic conditions such as Hepatitis C, Multiple Sclerosis, Growth Hormone Deficiency and Hemophilia among others. Prescriptions for Biotech medications may be subject to step therapy protocols before Caremark can give authorization.

Biotech medications are delivered through Caremark's Specialty Pharmacy. You must call Caremark at 800-237-2767 or visit www.caremark.com to verify your coverage and request authorization for the biotech therapies or medications. Following is a list of some, but not all, of the biotech medications requiring delivery through Caremark's Specialty Pharmacy:

- **Hormone Therapies** – Humatrop, Geref, Norditropin, Lupron, Lupron Depot
- **Allergic Asthma** – Xolair
- **Psoriasis** - Stelara
- **Multiple Sclerosis** – Copaxone, Avonex, Betaseron, Novantrone, Rebif, Tysabri
- **Hepatitis B & C** - PEG, Intron/Rebetol, Roferon, Infergen, Copegus, Pegasys, Incivek, Victrelis
- **Arthritis** (Osteo and Rheumatoid) – Kineret, Enbrel, Humira, Remicade, Synvisc, Hyalgan
- **Respiratory Syncytial Virus** – Synagis
- **Pulmonary Hypertension** – Tracleer, Revatio, Flolan, Letairis, Remodulin, Ventavis
- **Anemia** – Epogen, Procrit, Neupogen, Leukine, Aranesp, Neumega
- **Immune Deficiency** – IGIV and others
- **HIV** - Fuzeon
- **Bleeding Disorders** – Recombinant and Monoclonal Factors VIII & IX, Stimate
- **Rheumatoid Arthritis** – Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan

How The Prescription Plan Works Based on the Medical Plan you enroll in

- If you enroll in the UHC Option 1 Medical Plan: You need to enroll in the Prescription Plan separately in order to receive any prescription coverage.
- If you enroll in the UHC HSA Medical Plan: The prescription coverage is included as part of the Medical Plan. You pay the full cost of your prescription until you meet the medical plan deductible. Once you meet the medical plan deductible you will have prescription drug coverage according to the prescription plan design summarized in the chart, except the out-of-pocket maximum for the UHC HSA Medical Plan applies.
- If you enroll in the UHC Standard Medical Plan: The prescription plan design does NOT apply with this medical plan. The prescription coverage is included in the Medical Plan. Generics have a \$15 co-pay at retail and a \$30 co-pay at Mail Order. For all other drugs, you pay the full cost of your prescription until you meet the medical plan deductible. Then you pay the co-insurance of 20%, while plan pays 80% and the out-of-pocket maximum for the Standard Medical Plan applies.

You must use a participating pharmacy. There is no benefit paid if you use a non-participating pharmacy. If you must use a non-participating pharmacy in an emergency situation, you pay the full cost of the prescription and submit a claim for reimbursement. Reimbursement will be subject to the network-discounted price, minus your copay or coinsurance.

Your coinsurance is not reimbursed through the Medical Plan. Also, your coinsurance does not count toward the Medical Plan annual deductible and out-of-pocket maximum.

PRESCRIPTION PLAN

What the Prescription Plan Covers

The cost of prescriptions is covered if the medications:

- require a prescription to be dispensed;
- are purchased from a licensed pharmacist
- are dispensed according to the written guidelines of the physician;
- are prescribed for the treatment of an illness, sickness or injury;
- are prenatal vitamins; or
- are prescribed for birth control.

What the Prescription Plan Does Not Cover (this list is not intended to be all inclusive)

- medications not approved for general use by the Food and Drug Administration;
- vitamins except those required to be dispensed by a pharmacist and used for the treatment of an injury, illness or sickness;
- Norplant (contraceptive injectable);
- fluoride and fluoride products;
- allergy serums;
- nutritional supplements;
- diet supplements;
- food supplements;
- miscellaneous diabetic supplies, i.e. glucose tabs, insulin pumps, glucose monitors, lancet devices;
- other Rx devices, i.e. ostomy supplies, glucose monitors;
- nutritional food replacements and supplements;
- infant formula;
- hormone replacement for gender reversal;
- over-the-counter medications; and
- Proton-Pump Inhibitor Medications

Exclusions and Limitations

Caremark reserves the right to exclude coverage of drugs that are being used for unapproved indications of medical conditions and/or dosage regimens determined to be experimental.

Coverage of drugs will be limited to the uses and indications for which the drug or device was licensed or for uses and indications, which are recognized in accordance of generally accepted professional medical standards in the U.S. medical community as being safe, effective and medically appropriate for use in the treatment of a condition.

In order to ensure that the pharmacy benefit is being administered in the most clinically appropriate, cost-effective way, Caremark reserves the right to:

- exclude coverage of drugs that are for unapproved indications or medical conditions, unless the use is in accordance with generally accepted medical standards and is supported by the medical literature;
- exclude coverage of dosage regimens that exceed the recommended dosing guidelines as approved by the FDA;
- deny coverage of a drug and/or drug regimen that may be deemed inappropriate based on the patient's medical condition, potential drug interaction, etc.;
- COX 2 inhibitors (Celebrex) are subject to prior authorization and step therapy protocols before Caremark can give authorization for coverage; and
- limit quantities of certain prescription drugs where it is clinically appropriate. Examples include: Viagra, Cialis, Levitra (entire class of erectile dysfunction medication).

PRESCRIPTION PLAN

Specialty Guideline Management

Caremark offers a medical management program that provides treatment guidelines for certain biotech and specialty drugs. Biotech and specialty drugs are high-cost injectable drugs used to treat chronic conditions such as, but not limited to, hepatitis-C, allergic asthma, psoriasis, hemophilia, RSV prevention, growth deficiency and rheumatoid arthritis, multiple sclerosis, osteoporosis and cancer.

Through the Specialty Guideline Management Program, Caremark will complete a Prior Authorization Review with your physician to ensure that the most appropriate drug treatment is being prescribed. Using current evidence-based medical guidelines, the primary drug treatment recommended for your underlying medical condition will be identified. If primary drug treatment for patient's underlying condition has not been attempted, Caremark will deny coverage for current prescription.

If you or a covered dependent are currently taking one of these drugs, or are prescribed one in the future, Caremark will notify you and your physician.

Specialty Co-pay Card Program

Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the Member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Mail Service Prescription Program

The Mail Service Program, administered by Caremark, provides a convenient and cost-effective way to purchase long-term medications, maintenance medications, or medication that requires a letter of medical necessity. There is a copay for up to a 90-day supply after the deductible. Long-term maintenance medications must be obtained through the Caremark's Mail Service Program or obtained at a CVS Retail Store. This provides you with a convenient and cost-effective way to purchase a 90-day supply of maintenance medication. Maintenance medications include those prescriptions drugs you take on an ongoing basis for conditions such as diabetes, ulcers, arthritis or heart disease.

The prescription program requires the use of generic drugs when they are available. Many, but not all, drugs are available in a generic form. All prescriptions are filled with the generic version when available, even when Dispensed As Written (DAW) is indicated on your prescription. Before substituting a generic drug, Caremark will contact the prescribing physician to discuss the generic substitution, even if Dispense As Written, (DAW) is indicated on the prescription.

If you wish to have the brand name drug rather than the generic equivalent, your cost for the drug is higher. If you choose a brand name medication, you will be responsible for the brand copay or coinsurance plus the cost difference between the brand name and generic drug. If a generic drug is not available, you pay either the brand/Preferred Drug List or the brand/Non-Preferred Drug List copay or coinsurance for the prescription.

Biotech drugs are limited to the Mail Service Program only, and are subject to a \$125 copay, and prior authorization through Caremark for a 30-day supply.

How the Mail Order Prescription Plan Works

To use the prescription mail order program:

- ask your doctor to give you a new prescription for your maintenance medications and indicate a 90-day supply with three refills on the prescription;
- call Caremark's Customer Service at 800-421-5501 to request a mail service order form or you can go to a CVS Retail Store to fill the prescription;

PRESCRIPTION PLAN

- if you choose to call Caremark, you should find out if your prescription is for a generic, Preferred Drug List or brand name medication; and
- send the order form, your prescription and your payment to: CVS Caremark, PO Box 94467, Palatine, IL 60094-4467.

To review your mail order prescriptions, you can call 800-344-8075 or go online to www.caremark.com.

Prescriptions Available Only Through Mail Service

Some prescription medications are filled only through the mail order program. These prescription medications include, but are not limited to:

- **Biotech medications:** Genetically engineered drugs typically high cost injectables used to treat rare, chronic conditions such as Rheumatoid Arthritis, Hepatitis C, Multiple Sclerosis, Growth Hormone Deficiency and Hemophilia. Biotech medications are usually only available through the Mail Service Program, and are limited to a 30-day supply. Prescriptions for Biotech medications may be subject to step therapy protocols before Caremark can give authorization; and
- **Erectile Dysfunction Drugs (e.g. Viagra, Cialis):** Limited to 30 pills for a 90-day supply, or 10 pills for a 30-day supply.

The following medications also require submission of a letter of medical necessity with the mail service profile:

- **Retin A:** Dispensed only with a non-cosmetic diagnosis; and
- **Vitamins:** Prescription vitamins, other than prescription prenatal vitamins.

Dermatology Management Program

Certain dermatological products will become part of Specialty Guideline Management, which incorporates review for appropriate FDA-approved indications and clinically-based guidelines. Program management may require Prior Authorization requests, Step Therapy and Quantity Limits. Examples of dermatological products that may be subject to Specialty Guideline Management include, but are not limited to therapies for the treatment of acne, fungal infections, and psoriasis.

If a Claim for Benefits is Denied

You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed. See the Administrative Information section for specific procedures to request a review of a denied claim.

DENTAL PLAN

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

DENTAL PLAN

Introduction

This section is designed to provide you with information about the following Dental benefit plans. Based on the zip code for your address of record, these options may be available to you. The dental options differ in your choice of dentists, the level of benefits, and how benefits are paid.

- Cigna Dental Preferred Provider Organization (PPO) Plan;
- Cigna Dental HMO Plan; and
- Cigna Dental Indemnity Plan.

The Cigna Dental Preferred Provider Organization (PPO) Plan

The Dental PPO Plan is a fee-for-service plan providing coverage for basic, preventive, and restorative dental care, as well as orthodontia, once you satisfy an annual deductible. You may choose to receive care from any licensed dental provider. When you choose to receive care from a provider who participates in Cigna Advantage Network, the plan pays a higher benefit. Dentists who participate in the Cigna Advantage Network have contracted with Cigna to provide dental care at reduced fees. These fees are usually lower than the fees charged by providers who do not participate in Cigna Advantage Network. Preventive care received from a Cigna Advantage Network dentist is not subject to the annual deductible.

Cigna Dental HMO Plan

When you participate in the Cigna Dental HMO Plan, you select a primary care dentist who coordinates all your dental needs and makes any necessary referrals. You do not pay a deductible. There is no annual maximum. You pay a co-pay for each service. Co-pays are based on a fixed fee schedule – a patient charge schedule – for each covered service. Plan coverage may not be available in all areas.

The Cigna Dental Indemnity Plan

If you live in an area where a Dental PPO plan is not available, you will be provided coverage through the Cigna Dental Indemnity Plan. This option is a fee-for-service plan, which pays benefits based on the usual and prevailing charges for services in a particular geographic area. You and your dependents may receive care from any qualified licensed dentist.

No Coverage Option

You may also choose to waive dental coverage.

DENTAL PLAN**Cigna Dental PPO Plan Highlights**

Plan Benefits	Administered by Cigna	
	<u>In-Network*</u> CIGNA DPPO ADVANTAGE	<u>Out-of-Network*</u> INCLUDES CIGNA PPO OR PROVIDERS NOT LISTED ON THE CIGNA WEBSITE AS CIGNA PPO ADVANTAGE
<u>Reimbursement Levels</u>	All services from Cigna DPPO Advantage Providers and approved by the plan	Your choice of licensed providers
<u>Calendar Year Maximum</u>	\$1,500	\$1,250
<u>Annual Deductible</u>	\$25 Individual \$75 Family	\$50 Individual \$150 Family
<u>Routine Preventive Care</u> Oral exams, cleanings, fluoride applications (2 times/year) Bitewing x-rays Full Mouth and panoramic x-rays (every 3 years)	Plan pays 100% No Annual Deductible	Plan pays 80% After annual deductible
<u>Diagnostic Emergency Care, Space maintainers, and Sealants (each tooth, every 3 years)</u>	Plan pays 100% No annual deductible	Plan pays 80% After annual deductible
<u>Basic Restorative</u> Fillings and root canals Osseous and oral surgery, periodontal scaling, and root planing Denture adjustments and repairs Extractions	Plan pays 80% After annual deductible	Plan pays 70% After annual deductible
<u>Major Restorative</u> Crowns / Dentures / Bridges	Plan pays 60% After annual deductible	Plan pays 50% After annual deductible
<u>Orthodontia</u> (Braces)	Plan pays 50% After annual deductible \$1,250 lifetime maximum**	Plan pays 40% After annual deductible \$1,000 lifetime maximum**

* Dentists listed on Cigna.com that are not noted as DPPO Advantage providers, have agreed to discount their fees, however, claims are paid at the out-of-network coverage level as seen in the chart. Dentists that have no affiliation with Cigna – these claims are reimbursed based on usual and prevailing (U&P) charges. Any charges in excess of U&P are the responsibility of the patient.

** Orthodontia payments are included in the calendar year maximum.

DENTAL PLAN

Cigna Dental Indemnity Plan Highlights

Plan Benefits*	Administered by Cigna Out-of-Network
<u>Calendar Year Maximum</u>	\$1,500*
<u>Annual Deductible</u>	
Individual	\$25 Individual
Family	\$75 Family
<u>Routine Preventive Care</u>	
Oral exams, cleanings, fluoride applications (2 times/year) Bitewing x-rays Full Mouth and panoramic x-rays (every 3 years)	Plan pays 100% No annual deductible
<u>Diagnostic</u>	
Emergency Care, Space maintainers, and Sealants (each tooth, every 3 years)	Plan pays 100% No annual deductible
<u>Basic Restorative</u>	
Fillings and root canals Osseous and oral surgery, periodontal scaling, and root planing Denture adjustments and repairs Extractions	Plan pays 80% After annual deductible
<u>Major Restorative</u>	
Crowns / Dentures / Bridges	Plan pays 60% After annual deductible
<u>Orthodontia</u> (Braces)	Plan pays 50% After annual deductible
	\$1,250 lifetime maximum**

* Orthodontia payments are included in the calendar year maximum.

** The plan pays benefits based on the usual and prevailing rate for a particular geographical area. Charges over the usual and prevailing rate are not reimbursed through the plan.

How the Dental PPO Plan Works

The Dental PPO Plan pays benefits based on:

- for in-network dentists – a percentage of the pre-negotiated fee; or
- for non-network dentists – a percentage of the usual and prevailing charge.

Annual Deductible

The annual deductible is the amount of money you pay each year before the plan begins to pay benefits for covered expenses. The deductible must be met before many services are payable. Preventive care, when provided by network dentists, is not subject to the annual deductible.

For the Cigna Dental PPO Plan:

- the in-network individual deductible amount is \$25 and \$50 for out-of-network;
- the in-network family deductible amount is \$75 for you and your family and \$150 for out-of-network; and
- routine preventive care, when received from a network provider, is not subject to the annual deductible and is paid at 100%. If you receive care from an out-of-network provider, you are subject to the annual deductible of \$50 and the plan pays 80%.

Annual Benefit Maximum

The annual benefit maximum is the total individual benefit amount the plan pays each year. You are responsible for expenses over the annual maximum amount. Reimbursement for orthodontia services is included in the annual benefit maximum:

- the annual benefit maximum for the Cigna Dental PPO Plan for in-network services is \$1,500 per individual and \$1,250 for out-of-network services (this includes orthodontia).

The annual benefit maximum does not include charges over the usual and prevailing amount, or services not covered by the dental plan.

Orthodontia Treatment Maximum

There is a lifetime limit for orthodontia treatment. Treatment begins when the first orthodontic appliance is installed and ends when the last orthodontic appliance is removed:

- the lifetime orthodontia treatment maximum for the Dental PPO Plan for in-network care is \$1,250 and \$1,000 for out-of-network care; and
- if you elect the Cigna Dental PPO Plan and elect no coverage the following year, no benefits will be paid in the second year. You must elect dental plan coverage for the course of the orthodontia treatment.

How the Cigna Indemnity Dental Plan Works

Because the Cigna Dental PPO Plan may not be available in all areas, you may be offered dental coverage through the Cigna Dental Indemnity Plan. This fee-for-service plan provides coverage based on the usual and prevailing charge for services. You and your dependents may receive care from any qualified licensed dentist in your area:

- you pay an annual deductible (\$25 individual, \$75 family) for all dental services;
- plan pays 100% for Preventive and Diagnostic Care, not subject to deductible;
- plan pays 80% for Basic Restorative expenses, after annual deductible;
- plan pays 60% coinsurance on Major Restorative expenses, after annual deductible;
- plan pays 50% on Orthodontia services, after annual deductible;
- you must file claims with the plan;
- the annual benefit maximum for the Cigna Dental Indemnity plan is \$1,500 per individual regardless of where services are performed; and
- the lifetime orthodontia treatment maximum for the Cigna Dental Indemnity plan is \$1,250, regardless of where the services are performed.

DENTAL PLAN

Predetermination of Benefits

Predetermination of benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required. The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted. Cigna will determine covered dental expenses for the proposed treatment plan.

If there is no predetermination of benefits, Cigna will determine covered dental expenses when it receives a claim. Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed \$200. Predetermination of benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

What the Dental PPO and Indemnity Plans Cover

To be eligible for reimbursement under the Cigna Dental PPO Plan or the Cigna Dental Indemnity plan all services and supplies must be prescribed or approved as necessary by a licensed dentist. Services must be performed or supplied by a licensed dentist or a licensed hygienist under the supervision of a licensed dentist.

If a dental procedure involves the use of a local anesthetic like Novocain, the expense for the local anesthetic is included in the usual and prevailing charge for the procedure. If the dentist charges separately for the procedure and the anesthetic, the charges will be added together and the maximum allowance will be the usual and prevailing charge for the procedure performed.

The following services and supplies are covered under the Cigna Dental PPO Plan.

Preventive and Diagnostic Services

- two oral examinations in any calendar year;
- routine cleanings (two per year);
- bitewing X-rays twice during any calendar year;
- full mouth X-rays (once every 3 years);
- fluoride application (2 per calendar year);
- sealants to posterior teeth; one treatment per tooth every three years, up to age 19;
- emergency treatment of dental pain;
- space maintainers that are fixed and unrelated to orthodontic treatment;
- office visits during regular office hours;
- office visits after regular office hours (payment will be made on the basis of the service rendered or visit, whichever is greater);
- consultation by a specialist; and
- prophylaxis, including scaling and polishing, limited to two per calendar year.

X-ray and Pathology

- except for injuries, film fees include examination and diagnosis;
- single films, to a maximum of 13;
- entire denture series consisting of at least 14 films, including bitewings if necessary (once every three years);
- intra-oral, occlusal view maxillary or mandibular;
- upper or lower, extra-oral;
- bitewing films, including examination, limited to two per calendar year;
- panorama survey, maxillary and mandibular, single film (considered an entire denture series);
- biopsy and examination of oral tissue;

DENTAL PLAN

- study models, non-orthodontic; and
- microscopic examinations.

Space Maintainers (non-orthodontic)

- includes all adjustments within six months after installation;
- fixed space maintainer (band type);
- removal acrylic with round wire rest only;
- stainless steel clasps and/or activating wires; and
- removal, fixed or cemented inhibiting appliance to correct thumb sucking.

Basic Restorative Services**Oral Surgery**

- local anesthesia and routine post-operative care.

Extractions

- uncomplicated;
- surgical removal of erupted tooth;
- post-operative visits, (sutures and complications) after multiple extractions and impaction; and
- removal of impacted tooth (soft tissue, partially bony, and completely bony).

Alveolar or Gingival Reconstructions

- alvelectomy (edentulous or in addition to removal of teeth);
- alveoloplasty with ridge extension;
- removal of palatal torus or mandibular tori; and
- excision of hyperplastic tissue or pericoronal gingival.

Dental Cysts or Newplasms

- incision and drainage of abscesses; and
- removal of cyst or tumor.

Other Surgical Procedures

- salolithomy, removal of salivary calculus;
- closure of salivary fistula;
- dilation of salivary duct;
- transplantation of tooth or tooth bud;
- removal of foreign body from bone or from soft tissue;
- maxillary sinusotomy for removal of tooth fragment or foreign body;
- closure of oral fistula of maxillary sinus;
- sequestrectomy of osteomyelitis or bone abscess, superficial;
- condylectomy of mesiscectomy of temporomandibular joint;
- radical resection of mandible with bone graft;
- crown exposure to aid eruption;
- frenectomy;
- suture of soft tissue injury;
- injection of sclerosing agent into temporomandibular joint;
- treatment of trigeminal neuralgia by injection into second and third divisions; and
- osseous surgery.

Anesthesia

- general and IV sedation, only when medically necessary (nitrous oxide is not covered);

DENTAL PLAN

Restorative Dentistry

- excluding inlays, crowns (other than stainless steel), and bridges; multiple restorations and one surface will be considered a single restoration;
- amalgam filling;
- silicate cement filling;
- plastic filling;
- composite filling;
- pin retention when a part of a filling restoration;
- stainless steel crowns;
- adding teeth to partial denture; and
- replace extracted teeth, including clasps.

Endodontics

- pulp capping;
- therapeutic pulpotomy (in addition to restoration) and vital pulpotomy; and
- remineralizations, (calcium hydroxide, temporary restoration).

Root Canals

- necessary X-rays and cultures, but excluding final restoration;
- canal therapy, traditional or Sargenti method; and
- apicoectomy.

Recementation

- Inlay, crown or bridge.

Major Services

Restorative

- gold restorations and crowns are covered only when teeth cannot be restored with a filling material; and
- inlays, one or more surfaces.

Crowns (jackets and caps)

- acrylic or acrylic with gold or non-precious metal;
- porcelain or porcelain with gold or non-precious metal;
- non-precious metal (cast);
- gold (full cast or $\frac{3}{4}$ cast); and
- gold dowel pin.

Prosthodontics

- bridge abutments (see crowns).

Pontics

- cast gold (sanitary);
- cast non-precious metal;
- slotted facing (Steele's);
- slotted pontic (Tru-Pontic type);
- porcelain fused to gold or non-precious metal; and
- plastic processed to gold or to non-precious metal.

Removal Bridge (unilateral)

- one-piece casting, gold, or chrome cobalt alloy clasp attachment (all types), including pontics.

Repairs

- crowns;
- bridges;
- dentures (full and partial);
- broken dentures, no teeth involved;
- partial denture repairs (metal); and
- replacing missing or broken teeth.

Dentures and Partial Dentures

- fees for dentures, partial dentures and relining, including adjustments within six months after installation; specialized techniques and characterizations are not eligible;
- complete upper and/or lower dentures;
- partial acrylic upper and/or lower with gold or chrome cobalt alloy clasps, all teeth and two clasps (additional clasps are extra);
- simple stress breakers;
- stayplate;
- office reline, cold cure, acrylic;
- denture reline;
- special tissue conditioning;
- denture duplication (jump case); and
- adjustment to denture more than six months after installation.

Orthodontia and How Benefits Are Paid Under the PPO and Indemnity Plans

The plan covers orthodontic procedures made in connection with the movement of teeth by means of an active appliance to correct the position of maloccluded or malpositioned teeth, including diagnostic services required by one or more of the following:

- overbite or overjet;
- crossbite; and
- upper and lower arches in either protrusive or retrusive relation of at least one cusp.

Orthodontia Treatment Plan

Orthodontic benefits are paid according to when treatment begins. The first expenses for an orthodontia service or supply must be submitted with a treatment plan that includes:

- a description of the recommended treatment;
- an estimate of how long treatment will take to complete;
- the estimated total charge for the treatment; and
- any supporting pre-treatment X-rays, study models or other diagnostic records that the benefits administrator may request.

A down payment of 25% of the total fee is charged at the beginning of the treatment. This is payable at 50% by the Cigna Dental PPO Plan. The remaining balance is prorated in quarterly payments over the course of the treatment period. Quarterly payments are made only when the provider submits evidence of continued treatment. This is payable by the Cigna Dental PPO Plan at 50% for care received from network providers and 40% for care received from out-of-network providers. Under the Cigna Dental Indemnity plan this is payable at 50% regardless of provider.

If orthodontia treatment had begun before your effective date of coverage

You must submit a treatment plan from your orthodontist. This plan must include:

- the total fee for the treatment;
- the original date of treatment; and
- the date when the bands were originally placed.

DENTAL PLAN

In such cases, the benefits will be determined by calculating the total dental plan liability, the number of months you are eligible for coverage, and the monthly payment.

You should remember that:

- the annual deductible applies each calendar year unless satisfied by other dental services; and
- payments made for orthodontia are also applied to the plan's annual benefit maximum. If you have other dental work in the same calendar year, the payments for orthodontia may be reduced accordingly.

If orthodontia treatment begins after your effective date of coverage

The first expense for an orthodontic service or supply must be submitted in connection with a treatment plan. Payment for orthodontia is made as the work progresses as follows:

For care received from in-network providers:

- 25% of the total fee is the allowable down payment (installation fee). This is payable at 50%; and
- the balance is prorated in quarterly payments over the course of treatment, divided by the number of months of treatment. This is payable at 50%.

For care received from out-of-network providers:

- 25% of the total fee is the allowable down payment (installation fee). This is payable at 40%; and
- the balance is prorated in quarterly payments over the course of treatment, divided by the number of months of treatment. This is payable at 50%.

If treatment begins before your effective date of coverage

The first expense for an orthodontic service or supply must be submitted in connection with a treatment plan. Payment for orthodontia is made by determining the total liability under the dental plan, the number of eligible months and the monthly payment. Plan benefits will be determined on a pro-rated basis, considering the remaining balance and the number of months remaining in the treatment plan.

What the Dental PPO and Indemnity Plans Do Not Cover

The services and supplies described in this section are specifically excluded under the dental plan, even if prescribed by a dentist. This list is not intended to be all-inclusive.

Work-related injury

Charges in connection with:

- injury arising out of, or in the course of, any work for wage or profit;
- sickness covered by any Workers' Compensation law, occupational disease law or similar law; or
- services covered under any Workers' Compensation plan.

Government plan

Charges for a service or supply that is:

- furnished by or for the United States government or any other government, unless payment of the charge is required by law; or
- provided by any law or governmental plan under which the patient is or could be covered, excluding Medicaid, Medicare, and benefits in excess of those of any private insurance program or to the non-governmental program.

Above usual and prevailing

Charges for services, treatments, supplies or medications essential to the care of the covered individual which are greater than:

- the actual charges for such services, treatment, supplies, or medications; or
- the amount normally charged for comparable services, treatments, supplies, or medications by most providers in the locality where the charges were incurred when furnished to an individual of

DENTAL PLAN

the same sex and age for a similar sickness or injury. The benefits administrator determines the allowable amount for each charge.

Experimental or investigational

Charges for services or supplies under study and which are not recognized as safe and effective for diagnosis for treatment. This includes:

- all phases of clinical trials;
- all treatment protocols based on those used in clinical trials or medications not approved by the Federal Food and Drug Administration; and
- approved medications used for unrecognized treatment indications.

Charges for services furnished by a family member

- a spouse, parent, child, brother, sister, or any person residing in the home.

Charge for a replacement, alteration or modification

Charges for a replacement, alteration or modification of a crown or gold restoration, a full or partial removable denture, a removable or fixed bridge, or for adding teeth to any of these, unless the following conditions are met:

- the dentist must supply a statement indicating that the appliance cannot be repaired; and
- the appliance must be at least 5 years old; and
- treatment must begin after the participant has been covered under the plan for 24 consecutive months; or
- the replacement is to replace one or more natural teeth for the first time, which were extracted while the participant was covered under the dental plan.

Charge for the initial installation for a full or partial removable denture, or a removable or fixed bridge

Charges for the initial installation for a full or partial removable denture, or a removable or fixed bridge if it includes the replacement of one or more natural teeth missing before the participant became covered under the dental plan. This does not apply if one of the following conditions is met:

- the appliance includes the replacement of a natural tooth removed while the participant was covered under the dental plan;
- the participant has been covered by the plan for 24 consecutive months; and
- the tooth was not an abutment to an appliance installed during the prior 5 years.

Crown and gold restorations are only covered when treatment is for decay or injury

Crown and gold restorations are only covered when treatment is for decay or injury when the tooth cannot be restored with a filling material, when the tooth is an abutment to a covered partial denture or fixed bridge, or when approved by the benefits administrator.

Porcelain crowns on or replacing a tooth behind the second bicuspid, etc.

Porcelain crowns on or replacing a tooth behind the second bicuspid are reimbursed at the same benefit level as if they were acrylic veneered crowns.

Cosmetic charges

Any charge for service furnished for cosmetic purposes, including the alteration, bleaching, or extraction and replacement of sound teeth for the purpose of changing appearance. Facings on crowns, or pontics, are always considered cosmetic. This does not apply if the service is needed as a result of accidental injuries sustained while covered under the plan.

Accidental injury

Any charge in connection with an injury if the charge is payable under a medical plan under which you are covered. A charge that is not payable under the medical plan may be considered by the dental plan.

DENTAL PLAN**Temporomandibular Joint Disorder (TMJD)**

Charge in connection with treatment of TMJD of malocclusion involving joints or muscles by methods including but not limited to, crowning, wiring, or repositioning teeth.

Charge for injury or condition caused by war or similar event**Treatment before the effective date of coverage**

Any charges for a course of dental work that was begun before you or your dependents were covered under the dental plan (not applicable to orthodontia), including:

- any appliance or modification of an appliance if an impression was made before the effective date of coverage;
- a crown, bridge, or gold restoration, if the tooth was prepared before the effective date of coverage; and
- root canal therapy, if the pulp chamber was opened before the effective date of coverage.

Charge for vehicular accident

Any injury, condition, illness or disease incurred as a result of any accident involving an automobile, boat, plane, dirt bike, motorcycle, bicycle, bus or other vehicle. You may not elect to make the dental plan primary to any vehicular insurance you have. The dental plan may consider benefit payments for charges incurred as the result of a vehicular accident for which expenses are not recoverable under any form of insurance or other indemnification. Proof in a form acceptable to the dental plan may be required under this provision.

Other Exclusions (this list is not intended to be all inclusive)

- service not reasonably necessary or not customarily performed, for the dental care of a specific condition;
- service not furnished by a dentist. The services of a licensed dental hygienist under the direction of a dentist, or an X-ray ordered by a dentist are covered;
- replacement of lost or stolen appliances;
- appliances, restorations or procedures needed to alter vertical dimensions, or restore occlusion, or splinting or correcting attrition or abrasion;
- tooth implants;
- myofunctional therapy;
- athletic mouth guards;
- oral hygiene, dietary or plaque control programs, or other educational programs;
- duplicate prosthetic devices or appliances;
- prescribed medications covered by any prescription plan;
- services resulting from the commission of a felony;
- treatment when confined in a prison, jail, or other penal institution;
- services for which you would be required to pay in the absence of dental reimbursement coverage;
- completion of claim form, telephone consultations, or failure to keep a scheduled visit;
- dental treatment received outside of the United States and its territories, except for emergency treatment of an accident or sudden onset of an illness, when a participant resides in that country or when a participant is on assignment in that country for the employer;
- services or supplies rendered by providers other than those specifically covered by the dental plan;
- examinations or treatment ordered by a court in connection with legal procedures.

Treatment in Progress

If certain dental treatment is in progress when you leave the Company, the dental plan may continue coverage for up to 90 days after your departure. This applies when:

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- an impression was taken for dentures or fixed bridgework;
- a tooth was prepared for crown work;
- work was begun for root canal therapy (the dental plan will only pay for the completion of the root canal); or
- orthodontic treatment has already begun.

Cigna Dental HMO Plan Highlights

Administered by Cigna

Plan Benefits	In-Network
<u>Reimbursement Levels</u>	All care must be received from network providers
<u>Calendar Year Maximum</u>	No dollar maximum
<u>Annual Deductible</u>	
Individual	None
Family	None
<u>Routine Preventive Care</u>	
Oral exams, cleanings, fluoride applications (2 times/year) Bitewing x-rays Full Mouth and panoramic x-rays (every 3 years)	Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.
<u>Preventive & Diagnostic</u>	
<u>Emergency Care</u>	Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.
<u>Space maintainers</u>	
Sealants (each tooth, every 3 years)	
<u>Basic Restorative</u>	
Fillings and root canals Osseous and oral surgery, periodontal scaling, and root planing Denture adjustments and repairs Extractions	Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.
<u>Major Restorative</u>	
Crowns Dentures Bridges	Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.
<u>Orthodontia</u>	
(Braces)	Reduced, fixed, pre-set charges for all covered services. See the Patient Charge Schedule for specific charges.

Cigna Dental HMO Plan

The Cigna Dental HMO Plan is a managed dental care plan featuring:

- no charge for most preventive and basic dental services;
- reduced fees for other covered services;
- no claim forms; and
- no annual dollar maximums.

DENTAL PLAN

How the Cigna Dental HMO Plan Works

You may receive dental coverage through the plan if you live in an area where the Cigna Dental HMO Plan is available. Except in cases of emergency or with prior approval from Cigna, you are required to have all your dental care provided by dentists who are members of the Cigna Dental Care Plan network. When you join the Cigna Dental HMO Plan, you must select a dental office from a list provided by Cigna Dental. You will be issued an ID card indicating the dental office you selected. If you do not select a network dentist, Cigna may assign one for you. Your network general dentist will coordinate all your dental care, including referrals to specialists as needed. You are responsible for identifying network providers in your area. A list is available at www.cigna.com, or by calling Cigna at 800-244-6224.

What the Cigna Dental HMO Plan Does Not Cover

Limitations on services covered by the plan

- **frequency** – The frequency of certain covered services, such as cleanings, is limited. The patient charge schedule lists any limitations on frequency;
- **specialty care** – Payment authorization is required for coverage of services by a network specialist;
- **pediatric dentistry** – Coverage for referral to a pediatric dentist ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. The network general dentist shall provide care after the child's 7th birthday; and
- **oral surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

The services or expenses listed below are not covered under the plan and are a covered individual's responsibility at the dentist's usual fees.

Exclusions (this list is not intended to be all-inclusive)

- services provided by a non-network dentist without Cigna Dental Health's prior approval (except emergencies);
- services related to an injury or illness covered under Workers' Compensation, occupational disease, or similar laws (Florida – this exclusion relates to such services paid under Workers' Compensation, occupational disease or similar laws.);
- services not listed on the Patient Charge Schedule;
- services provided or paid by or through a federal or state governmental agency or authority, political subdivision; or a public program other than Medicaid;
- services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance);
- nitrous oxide (general anesthesia and IV sedation are covered only when medically necessary and when provided in conjunction with covered procedures);
- prescription drugs;
- procedures, appliances, or restorations if the main purpose is to:
 - change vertical dimension (degree of separation of the jaw when teeth are in contact);
 - diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed on the Patient charge schedule; or
 - restore teeth that have been damaged by attrition, abrasion, erosion and/or abfraction (for California, the word "attrition" is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired);
- the completion of crown and bridge, dentures or root canal treatment already in progress on the date a covered person becomes covered by the Dental Plan. (**Note:** this exclusion does not apply to Texas residents, if the procedures are otherwise covered under your Patient Charge Schedule);

DENTAL PLAN

- replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse or neglect;
- services associated with the placement or prosthodontic restoration of a dental implant;
- services considered as unnecessary or experimental in nature. (California and Maryland residents: this exclusion should read, "Services considered unnecessary." Pennsylvania residents: this exclusion should read, "Services considered experimental in nature.");
- procedures or appliances for minor tooth guidance or to control harmful habits;
- hospitalization, including any associated incremental charges for dental services performed in a hospital (Benefits are available for Network Dentist charges for covered services performed in a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.);
- services to the extent a covered person is compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy (**Note:** This exclusion does not apply to Arizona, Maryland, North Carolina and Pennsylvania residents. For residents of Kentucky, services compensated under no-fault auto or insured motorist policies not excluded);
- crown and bridges used solely for splinting;
- resin bonded retainers and associated contics; and
- pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

Claims for Cigna Dental PPO and Indemnity Plans

You do not have to file claims for services received from network dentists. Your dentist will handle this paperwork for you.

To file a claim for dental services received from non-network dentists, you may obtain a claim form from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

When filing a claim you must provide this information:

- your Social Security number;
- the patient's full name, date of birth and relationship to you;
- an itemized bill from the dentist that includes name, address, and tax identification number, diagnosis, date of service, and charge; and
- indication of whether you want payment to be made to you or directly to the dentist.

A separate claim form should be filed for each family member. Send the completed forms to the address on your claim form. It is important that you complete the claim form in its entirety. Missing information may cause a delay in processing your claim.

Important Note: The plan will not make any payments on claims that are submitted more than one year after the end of the year in which expenses are incurred, regardless of whether you filed the claim for yourself or for your dependent(s), or whether your provider (dentist, laboratory, etc.) filed the claim on your behalf or on behalf of your dependent(s).

Claims for Cigna Dental PPO Plan

When you use a network dentist, there are no claim forms to be filed. You pay any applicable patient charges directly to the dentist.

If a claim for benefits is denied, you will be notified in writing. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed. See the Administrative Information section of this book for specific procedures to follow in requesting a review of a denied claim.

DENTAL PLAN**Subrogation of Benefits and Restitution**

Subrogation seeks to conserve the plan assets by imposing the expense for accidental injuries suffered by participants, including their eligible dependents, on those responsible for causing such injuries. If you and/or your dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your dependents apply to the plan for benefits and receive such benefits, the plan shall then have a first priority lien and/or an equitable lien by agreement for the full amount of the benefits that are paid to you and/or your dependents should you seek to recover any monies from the third party that caused the injuries. This includes any recovery that you may receive from the third party, his insurance carrier, any other insurance or benefits program or any other party settling on this behalf, including but not limited to workers compensation, uninsured or underinsured motorist programs, no-fault or traditional automobile insurance programs, or any other medical payment coverage (auto, homeowners or otherwise), whether through claims payment, compromise, settlement, judgment, verdict and/or any other payment.

We strongly recommend that if you are injured as a result of the negligence or wrongful act of a third party, you should contact your attorney for advice and counsel. However, the plan cannot and does not pay for the fees your attorney might charge.

Should you seek to recover any monies from the third party that caused your injuries, or his insurance carrier, any other insurance or benefits program or any other party settling on his behalf, you must give notice to the plan administrator within ten (10) days of when either you or your attorney first attempt to recover such monies. If litigation is commenced, you are required to give five days notice to the plan administrator of any pretrial conferences. Representatives of the plan reserve the right to attend such pretrial conferences.

The plan's lien and/or equitable lien by agreement arises through the operation of the plan. No additional restitution agreement is necessary. The plan administrator may, however, require you to sign a restitution agreement, before or after benefits are paid to you or your dependent. By accepting benefits from the plan, you agree that you will timely comply with any and all requests from the plan for documentation concerning any legal proceedings, settlement negotiations and/or medical information that may give rise to or affect the plan's right to subrogation and/or restitution. You also agree that you will not take any action that might impair, prejudice or discharge your right to recovery or the plan's right to subrogation and restitution.

The plan's lien is a lien and/or an equitable lien by agreement on the proceeds of any claims payment, compromise, settlement, judgment, verdict and/or payment received from the third party, his insurance carrier, any other insurance or benefits program and/or any other party settling on his behalf. By applying for and receiving benefits from the plan in such third party situations, you agree that there is a lien running in the plan's favor and to restore to the plan the full amount of the benefits that are paid to you and/or your dependents from the proceeds of any such claims payment, compromise, settlement, judgment, verdict and/or other payment, to the extent permitted by law.

By applying for benefits, you agree that the proceeds of any claims payment, compromise, settlement, judgment, verdict and/or payment received from the third party, his insurance carrier, any other insurance or benefits program and/or any other party settling on his behalf, if paid directly to you, will be held by you in constructive trust for the plan. The receipt of such funds makes you a fiduciary of the plan with respect to such funds and, therefore, subject to the fiduciary provisions and obligations of ERISA.

By applying for benefits, you agree that the proceeds of any claims payment, compromise, settlement, judgment, verdict and/or payment received from the third party, his insurance carrier, any other insurance or benefits program and/or any other party settling on his behalf, and paid to a person or entity other than you, including but not limited to, a trust, an attorney or an agent thereof, shall be held by such other person, entity or trust in constructive trust for the plan. The recipient of such funds is a fiduciary of the plan with respect to such funds and is subject to the fiduciary provisions and obligations of ERISA. The

DENTAL PLAN

plan reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the plan's subrogation or restitution rights.

By applying for benefits, you agree that any lien and/or equitable lien by agreement the plan may seek will not be reduced by any attorney fees, court costs or disbursements that you and /or your attorney might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the plan for the full amount of the lien. Further, you agree that any recovery will not be reduced by and is not subject to the application of the "common fund" doctrine, the "fund" doctrine and/or the "attorney fund" doctrine for the recovery of attorney's fees.

The plan does not require you to seek recovery whatsoever against the third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the plan for any of the benefits that you applied for and accepted.

In the event you fail to notify the plan as provided for above, and/or fail to restore to the plan such funds as provided for above, the plan reserves the right, in addition to all other remedies available to it at law or equity, to withhold any other monies that might be due you from the plan for past or future claims, until such time the plan's lien is discharged and/or satisfied.

Any and all amounts received from a third party by claims payment, compromise, settlement, judgment, verdict and/or other payments, must be applied **first** to satisfy your restitution obligation to the plan for the amount of expenses paid by the plan on behalf of a participant or beneficiary. The plan's lien is a lien of first priority for the entire recovery of funds paid on your behalf, regardless of how the recovery is worded or structured or for what purposes the recovery is designated. Where the recovery from the third party is partial or incomplete, the plan's right to restitution takes priority over the participant's or beneficiary's right of recovery, regardless of whether or not the participant or beneficiary has been made whole for his or her injuries or losses. The plan does not recognize and is not bound by an application of the "make whole" doctrine, the "fund" doctrine, the "collateral source rule" or any other equitable defenses that may affect the plan's right to subrogation or restitution.

You and your dependents may not assign your rights to settlement or recovery against a third party to any other party, including your attorney, without the plan's express, written consent.

No-Fault and Vehicular Dental Payments Coverage

In claims resulting from vehicular accidents in states where vehicular insurance contracts include provisions that relate to dental treatment, Cigna will pay covered expenses not paid by no-fault insurance, or seek reimbursement from the employee if dental benefits are recovered from both companies. The benefits paid will be coordinated to cover up to 100% of the benefits allowable under the plan.

You may not elect to make this plan primary to any vehicular insurance you have. The plan may consider benefit payments for charges incurred as the result of a vehicular accident for which expenses are not recoverable under any form of insurance or other indemnification. Proof in a form acceptable to the dental plan may be required.

Coordination of Benefits

If you or a member of your family is covered by another employer's dental plan, there may be some duplication of benefit coverage between the Cigna dental plan and the other dental plan. The Cigna dental plan has a specific provision, Coordination of Benefits.

See the "Medical Plan" section of this book for detailed information regarding Coordination of Benefits. This provision applies to the medical and dental plans.

VISION INSURANCE PLAN

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

VISION INSURANCE PLAN**Vision Insurance Plan Highlights**

This section of your Summary Plan Description is designed to provide you with information about the Vision Insurance Plan. EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate in-network providers near you, visit www.eyemed.com and choose the Access Network. You may also call EyeMed's Customer Care Center at 1-866-723-0513. EyeMed's Customer Care Center can be reached Monday – Saturday 7:30am to 11:00pm EST and Sunday 11:00am to 8:00pm EST.

Administered by EyeMed Vision Care

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam Dilation as necessary Refraction	No charge	Up to \$35
Retinal Imaging	Up to \$39 co-pay	N/A
Exam – Contact Lenses Standard Contact Fit* Premium Contact Fit*	Up to \$55 90% of retail price	N/A N/A
Frames: Any available frames at a provider location	Up to \$130 allowance 20% off balance over \$130	Up to \$65
Standard Plastic Lenses Single Vision Bifocal Trifocal Standard Progressive Premium Progressive	\$5 copay \$5 copay \$5 copay \$70 copay \$70 copay, 80% of charge less \$120 allowance	Up to \$25 Up to \$40 Up to \$55 Up to \$40 Up to \$40
Standard Lens Options Standard scratch resistance UV coating Tint (solid and gradient) Standard polycarbonate Standard anti-reflective coating Other add-ons and services	\$0 \$15 \$15 \$40 \$45 80% of retail price	Up to \$11 N/A N/A N/A N/A N/A
Contact Lenses Conventional Disposable Medically necessary***	\$0 copay up to \$130 and 15% off over \$130 \$0 copay, up to \$130 \$0 copay, paid in full	Up to \$104 Up to \$104 Up to \$200
Additional Pairs Benefits	Members receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
LASIK or PRK from US Laser Network	85% of retail price or 95% of promotional price whichever is less	N/A

VISION INSURANCE PLAN

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Frequency		
Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Additional Discounts

Under the Plan, you may receive benefits for eyeglasses (frame and lenses) or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used.

The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceed any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

VISION INSURANCE PLAN

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at **866-723-0513**.

Covered Vision Services**Examination Benefit**

- **In-Network Benefit** – A Member is entitled to a paid-in-full eye examination, including dilation, performed by a Participating Provider.
- **Out-of-Network Benefit** – A Member is entitled to an eye examination with dilation, up to a \$35.00 retail value. The Member must pay at the point-of-service and will be reimbursed up to \$35.00 toward an eye examination after submitting a complete claim.
- **Member Pays** – There is a \$0 copayment for in-network benefit only.
- **Fitting and Follow up** – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
 - **Standard** Contact lens – spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. **Standard** benefit: member pays up to \$55 of the usual and customary charge.
 - **Premium** Contact Lens – all lens designs, materials and specialty fittings other than Standard Contact Lenses. **Premium** benefit: a 10% discount off of the usual and customary charge.
- **Out of Network, Fitting and Follow up** – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
 - **Standard** Contact lens – Not Available
 - **Premium** Contact Lens – Not Available
- **Benefit Frequency** – Once every twelve (12) months.

Contact Lens Benefit

- **In-Network Benefit** – In lieu of eyeglass lenses, all Members are entitled to conventional, disposable or medically necessary contact lenses for the amounts below. The Member is responsible for the balance over the allowance amount at the time of service.
 - **Conventional** – a \$130.00 allowance applied toward non-disposable contact lenses. The Member is responsible for 85% of the balance amount over \$130.00 at the time of service.
 - **Disposable** – a \$130.00 allowance applied toward disposable contact lenses. The Member is responsible for 100% of the balance over \$130.00 at the time of service.
 - **Medically Necessary** – a paid in full benefit toward medically necessary contact lenses.
- **Out-of-Network Benefit** – In lieu of the eyeglass lenses benefit, for contact lenses obtained from an out-of-network provider, a Member is entitled to the following:
 - **Conventional** – a Member is entitled to be reimbursed up to \$104.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
 - **Disposable** – a Member is entitled to be reimbursed up to \$104.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
 - **Medically Necessary** – a Member is entitled to be reimbursed up to \$200.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
- **Member Pays** – There is no copayment.
- **Benefit Frequency** – Once every twelve (12) months.

Frame Benefit

- **In-Network Benefit** – A Member is entitled to a \$130.00 allowance toward a frame with the purchase of prescription lenses. The Member is responsible for 80% of the balance over the \$130.00 at the time of service.

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- **Out-of-Network Benefit** – A Member is entitled to a reimbursement of up to \$65.00 toward any frame purchased from an out-of-network provider. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
- **Member Pays** – There is no copayment.
- **Benefit Frequency** – Once every twenty-four (24) months.

Lens Benefits

- **In-Network Benefit** – A Member is entitled to single vision, bifocal, trifocal, standard progressive and premium progressive lenses.
- **Member Pays** – There is a \$5 copay for single vision, bifocal and trifocal. For standard progressive there is a \$70 copay and for premium progressive there is a \$70 copay plus 80% of charge less \$120 allowance.
- **Lens Options** – A Member is entitled to the following lens options for the additional amounts set forth below:

	In-Network	Out-of-Network
Ultra Violet Coating	\$15	N/A
Tint (Solid & Gradient)	\$15	N/A
Standard Scratch Resistant	\$0	Up to \$11
Standard Polycarbonate-Adults	\$40	N/A
Standard Polycarbonate-Kids under 19	\$40	N/A
Standard Anti-Reflective	\$45	N/A
Polarized and Other Add-Ons	20% discount	N/A

- **Out-of-Network Benefit** – A Member is entitled to be reimbursed for the following: up to \$25.00 for single vision; up to \$40.00 for bifocal; up to \$55.00 for trifocal, up to \$40 for standard and progressive. The Member must pay the out-of-network provider in full at the point-of-service and file a complete claim to receive the reimbursement.
- **Benefit Frequency** – Once every twelve (12) months.

Note: Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits, no remaining balance.

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers;
- **High Ametropia** exceeding –10D or +10D in meridian powers;
- **Keratoconus** where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses;
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

The benefit may not be expanded for other eye conditions even if you, or your provider, deem contact lenses necessary for other eye conditions or visual improvement.

Retinal Imaging Benefit

Retinal imaging has been provided as a discount to your vision plan. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Savings on Laser Vision Correction

EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using a network provider in the

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U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call **877-5LASER6**.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at **877-5LASER6** to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

EyeMed Vision Care Discount Program

If you are eligible for medical coverage under the Ryder Medical Plan, you will automatically be enrolled in EyeMed Vision Care. This program is provided at no cost to you.

The program offers you and your dependents discounts from 20% to 60% off retail eyewear costs. When you use participating providers, the plan provides employees and their dependents with \$5.00 off routine eye exams and \$10.00 off a contact lens exam. To participate in the program, simply provide the plan ID 9238411 when visiting a participating provider to obtain eyewear. To locate participating EyeMed providers, call 866-723-0596.

Hearing Discount Benefit with Amplifon Hearing Health Care

EyeMed teamed up with Amplifon, the world's largest distributor of hearing aids and services, to add affordable hearing care to your EyeMed vision benefits package. Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids. For additional information, call 1-844-526-5432.

International Travel Solution

As an EyeMed member, you have access to international support and resources in 20 countries. From quick fix, temporary glasses to getting you in contact with a trusted provider. For additional information, call 1-513-765-2870.

Online Contact Lenses with ContactsDirect.com

You can apply your in-network contact lens benefit at contactsdirect.com by completing the online transaction form and the contacts will be delivered directly to your home.

Online Eyewear with Glasses.com

You can access eyewear by applying in-network vision benefits through www.glasses.com.

Limitations and Exclusions (this list is not intended to be all-inclusive)

Benefits are not provided for services or materials arising from:

- orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
- medical and/or surgical treatment of the eye, eyes or supporting structures;
- any eye or vision examination or corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan;
- services provided as a result of any Workers' Compensation law; and
- plano non-prescription lenses and non-prescription sunglasses (except for the 20% discount), and/or contact lenses. Two pair of glasses in lieu of bifocals. Services rendered after the date an

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Insured Person becomes an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Filing Claims and Appeals

The EyeMed network is always growing, and provider locations are subject to change. Therefore, we recommend calling EyeMed's Member Services Department 866-723-0513 or using the Provider Locator service through EyeMed's web site www.eyemed.com to locate the EyeMed Provider closest to you.

Before you go to a participating EyeMed Provider location for an eye exam, glasses or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Identification Card. If you should forget to take your card, be sure to say that you are participating in the Ryder Vision Insurance vision care plan so that eligibility can be verified. EyeMed Vision Care Customer Service can be reached at 866-723-0513.

When you receive services at a participating EyeMed provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses. If you choose a non-participating provider, you must complete an out-of-network claim form, attach detailed receipts and mail the information to EyeMed Vision Care. An out-of-network claim can be obtained from the EyeMed website.

Timeframes for Processing Claims

First American Administrators, Inc., a third-party administrator and wholly owned subsidiary of EyeMed ("hereinafter "FAA") will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Timeframes for Responding to Appealed Claims

If your claim is denied, in whole or in part, you may appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your appeal will be decided within 60 days after receipt. Your written letter of appeal should include:

- the applicable claim number or a copy of the FAA denial information or Explanation of Benefits, if applicable;
- the item of your vision coverage that the member feels was misinterpreted or inaccurately applied;
- additional information from the member's eye care provider that will assist FAA in completing its review of the member's appeal, such as documents, records, questions or comments.

You may authorize someone else to file and pursue a complaint or appeal on your behalf. If you do so, you must notify FAA/EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the complaint and/or appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

The appeal should be mailed or faxed to: FAA/EyeMed Vision Care, LLC, Attn: Quality Assurance Department, 4000 Luxottica Place, Mason, OH 45040. Fax: 513-492-3259. FAA/EyeMed will review your appeal for benefits and notify you in writing of its decision.

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Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 866-723-0513 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Enforce Your Rights

If your claim for vision benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

When you have completed all appeals mandated by ERISA, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)), *see*, 29 U.S.C. 1132(a)(1)(B), you have the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. Your Human Resources Department should be able to provide you with the name and contact information of your Plan Administrator...If you have any questions about this summary of vision care services or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

The Insured benefits are underwritten by Fidelity Security Life Insurance Company of America. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at www.eyemed.com or 1-866-723-0513.

FLEXIBLE SPENDING ACCOUNTS

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

FLEXIBLE SPENDING ACCOUNTS**Introduction**

This section is designed to provide you with information about the:

- Health Care Flexible Spending Account Plan; and
- Dependent Care Flexible Spending Account Plan.

Definition of Dependents for the Flexible Spending Accounts**Health Care Spending Account**

Under the Health Care Spending Account a dependent is a spouse or anyone else for whom you provide financial support and claim as a dependent on your federal income tax return, if the expenses are not payable under any other plan.

Dependent Care Spending Account

Under the Dependent Care Spending Account a dependent includes:

- your child, adopted child, stepchild or foster child, who is under age 13, who resides in your household for more than one-half of the year, who does not provide more than one-half of his or her support for the year and for whom you take a dependent exemption on your tax return. If you are divorced, special rules may apply;
- your physically or mentally disabled spouse incapable of self-care, who lives with you for more than one-half of the year; or
- any other disabled relative or household member who is principally dependent on you for support and who resides in your household for more than one-half of the year. A disabled dependent aged 13 or older must spend at least 8 hours a day in your home. A disabled dependent who is confined to an institution for care does not qualify.

A person cannot be an eligible dependent if the person is a dependent of another person who filed a joint tax return for the year with his or her spouse (other than you). Except, this does not apply with respect to a disabled dependent who is not a citizen, national or resident of the United States or a resident of Canada or Mexico.

Dependent care expenses eligible for reimbursement through the Dependent Care Spending Account are expenses incurred so that you or your legal spouse can work. If your spouse does not work, you may not participate in the Dependent Care Spending Account unless he/she meets certain earned income requirements and is either a full-time student or mentally or physically incapable of self-care.

FLEXIBLE SPENDING ACCOUNTS**Highlights of the Flexible Spending Accounts**

Account Name	Description/Eligible Expenses	Maximum Deposit/Restrictions
Health Care Spending Account	You may deposit a portion of your earnings in the account on a pre-tax basis to pay for health care expenses that are not fully reimbursed or partially reimbursed by the medical, prescription, dental, or vision plans (including deductibles and copays, but not coverage premiums or contributions).	<ul style="list-style-type: none"> • \$2,600 may be indexed annually. • Expenses must be incurred on or after the effective date of coverage. • Expenses must be incurred on or before the end of the year or the end of the grace period. • Expenses cannot be incurred after your termination date unless you contribute to a Health Care Spending Account on a post-tax basis, generally through a COBRA continuation election. • Claims may be incurred during the grace period from January 1 – March 15 of the following year. Claims incurred during the grace period may be applied to your current account or your account for the next year.

Account Name	Description/Eligible Expenses	Maximum Deposit/Restrictions
Dependent Care Spending Account	You may deposit a portion of your earnings in the account on a pre-tax basis to pay for day care expenses. Eligible expenses include actual care of your child, not costs for education, supplies, clothing or meals.	<ul style="list-style-type: none"> • Up to \$5,000 a year (this is the maximum amount your family may deduct from taxable income). • Deposit amounts may be limited for highly compensated employees. • Married couples who file separate tax returns are limited to \$2,500 per participant. In some cases, this amount may be even less, such as where the spouse has income of less than \$2,500. • Expenses must be incurred on or after the effective date of coverage and on or before the end of the calendar year.

You cannot transfer money from one account to the other, and you cannot use money from one account to cover expenses that should be claimed from the other account (i.e., you cannot use money from your Dependent Care Spending Account to cover medical expenses for your children).

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Payroll Deductions and Taxes

Deductions: The annual amount you decide to deposit into each account will be deducted from your pay in equal amounts according to the number of paychecks you receive each year. If a scheduled deduction is missed during the year, it must be made up through additional payroll deductions before the end of the calendar year. Missed payroll deductions are taken from the first and subsequent payroll checks until the missing deductions are collected.

Taxes: The money you deposit in the accounts is deducted from your pay before federal and most state and local taxes are calculated and withheld. This lowers your taxable income and reduces the earnings shown on your W-2 form. Once deposited, you never pay taxes on this money, even after it is paid back to you in the form of a reimbursement for eligible expenses.

Social Security Taxes: are not withheld from the amount of pre-tax dollars you deposit to the accounts. Because you are reducing the Social Security tax you pay, there is a chance that your future Social Security benefits could be reduced. If this happens, the reduction is generally very small.

Dependent Care Spending Account Limit for Higher-Paid Employees

The government sets limits on the maximum that certain highly compensated employees may contribute to tax-advantaged benefits. One of them is the Dependent Care Spending Account. You will be notified if these limits apply to you. In some years, notification of contribution limits may not be made before the start of contributions. If your contribution amounts exceed this limit, your contributions will be reduced during the year or may be refunded so that your annual contribution does not exceed this limit.

Health Care Spending Account (HCSA)

You can contribute up to \$2,600 (this amount may be indexed annually) to the Health Care Spending Account. Contributions deducted from your paycheck are deposited into your account. You will receive a YSA Flexible Spending Account Card. This card can be used to pay for eligible medical, prescriptions, vision and dental expenses (see the FSA Claims section for more details).

It is important to anticipate what your eligible health care expenses will be and set aside enough dollars to cover only those anticipated expenses. Per IRS Guidelines, money not used during the calendar year or during the grace period *must be forfeited*.

Eligible Health Care Spending Account Expenses

Expenses eligible for reimbursement must occur during the plan year or grace period. Examples of eligible expenses include, but are not limited to:

Dental and Orthodontic Care

- dental treatment;
- artificial teeth – dentures; and
- braces, orthodontic devices.

Therapy Treatments

- treatment for alcoholism or drug dependency;
- legal sterilization;
- acupuncture;
- physical therapy, medically prescribed for a specific diagnosis;
- X-ray treatments;
- fee to use swimming pool for exercises prescribed by a physician to alleviate specific medical conditions such as rheumatoid arthritis;

FLEXIBLE SPENDING ACCOUNTS

- smoking cessation programs;
- speech therapy; and
- vaccinations.

Fees/Services

- physicals;
- physician's fees and hospital services;
- laboratory fees;
- nursing services for care of a specific medical ailment;
- the Social Security taxes paid with respect to wages of a nurse where nurse's services qualify;
- services of Chiropractors; and
- Christian Science Practitioner fees.

Hearing Expenses

- hearing aids; and
- hearing aid battery.

Prescription Drugs

- medicine and drugs that require a prescription (drug name must be on receipt); and
- insulin and supplies.

Medical Equipment

- wheelchair or autoette, cost of operating and maintaining;
- crutches (purchased or rented);
- special mattress & plywood boards prescribed to alleviate arthritis;
- oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition;
- artificial limbs;
- support hose, if medically necessary;
- wigs, where necessary to the mental health of the individual who loses hair because of disease; and
- excess cost of orthopedic shoes over cost of ordinary shoes.

Assistance for the Handicapped

- cost of guide for a blind person;
- cost of note-taker for a deaf child in school;
- cost of Braille books and magazines in excess of the cost of regular editions;
- seeing eye dog, cost of buying, training, and maintaining;
- household visual alert system for deaf person;
- excess costs of specifically equipping automobile for handicapped person over the cost of an ordinary automobile; device for lifting handicapped person into automobile; and
- special devices, such as tape recorder and typewriter for a blind person.

Vision Care

- optometrist's or ophthalmologist's fees;
- prescription glasses;
- reading glasses;
- prescription sunglasses;
- contact lenses;
- saline solution and enzyme cleaners; and
- radial Keratotomy/PRK/Lasik surgery.

FLEXIBLE SPENDING ACCOUNTS**Psychiatric Care**

- services of psychotherapists, psychiatrists, psychologists and medical practitioners.

Miscellaneous Charges

- X-rays;
- expense of services connected with donating an organ;
- travel for medical purposes, must have a copy of the invoice from the provider showing the date of service;
- abortion;
- air conditioner, when necessary for relief from allergies or for relieving difficulty in breathing;
- deductibles, coinsurance payments, and copays under your health or dental care plans;
- expenses in excess of what is covered by the Ryder System, Inc. Medical, Prescription, Dental and Vision Plans;
- tutoring fees and special schools for children with severe learning disability caused by mental or physical impairments, including nervous system disorders;
- the cost of keeping a mentally or physically handicapped person in a special home;
- hearing care, including hearing aids and special telephone and television equipment for the deaf;
- birth control pills or other birth control items prescribed by your doctor;
- certain medical expenses paid as part of a life care fee under an agreement with a retirement home;
- nurse's board and wages;
- the cost of weight-loss programs advised by a physician to treat an existing disease;
- medical supplies and equipment such as thermometers, heating pads, oxygen, blood pressure monitoring equipment; arch supports, abdominal or back supports, truss, sacroiliac belt, and invalid chair;
- other medical and dental expenses not normally covered by insurance;
- transportation to receive health care;
- expenses paid for admission and transportation to a medical conference if the conference concerns a chronic illness suffered by you, your spouse or dependent. (To be eligible, the cost of the conference must be primarily for and necessary to the medical care for you, your spouse or your dependent. You must spend the majority of your time at the conference attending sessions on medical information. The cost of meals and lodging while attending the conference are not eligible for reimbursement);
- fertility treatments such as in-vitro fertilization and surgery, including an operation to reverse prior surgery that prevents you from having children;
- therapy received as medical treatment, including patterning exercises for a mentally handicapped child; and
- necessary legal fees paid to authorize treatment for mental illness.

For a complete list of IRS approved expenses, see IRS publication 502.

Ineligible Health Care Spending Account Expenses

Examples of expenses that are *not* eligible for reimbursement include, but are not limited to (this list is not intended to be all-inclusive):

Dental and Orthodontic Care

- teeth whitening or bleaching; and
- veneers

Therapy Treatments

- physical treatments unrelated to a specific health problem (i.e., massage for general well being);
- any illegal treatment;

FLEXIBLE SPENDING ACCOUNTS

- cosmetic surgery and procedures;
- hair transplant; and
- electrolysis.

Fees/Services

- payments to domestic help, companion, baby-sitter, chauffeur, etc. who primarily render services of a non-medical nature;
- nursemaids or practical nurses who render general care for healthy infants; and
- fees for exercise, athletic or health club memberships.

Prescription Drugs/Medications

- cost of illegal, nonprescription medication;
- cosmetic creams;
- hair loss products;
- vitamins/Nutritional supplements; and
- weight loss prescription drugs.

Disallowable Over-the-Counter Products (Some products may be allowed with a prescription from a doctor and a detailed receipt)

Include but are not limited to:

- acne medications and creams;
- allergy prevention/treatment;
- anti-gas;
- anti-itch;
- anti-diarrhea;
- asthma/wheezing/shortness of breath;
- athlete's foot/anti-fungal;
- birth control;
- cold/allergy;
- corn/callus removal;
- cough/cold/flu/fever reducer;
- cough/loosen phlegm;
- cough suppression including cough drops;
- dandruff/seborrhea/psoriasis medications;
- ear problems/ear drying/ swimmer's ear;
- ear wax;
- eye problems;
- fever blister medication;
- head lice treatments;
- heartburn or indigestion;
- hemorrhoid;
- jock itch/anti-fungal;
- laxative/stool softeners;
- menstrual discomfort;
- mouth pain products;
- nasal decongestant;
- nausea, vomiting, or motion sickness;
- pain relief/fever reducer;
- muscle aches;
- poison treatments;
- rashes (poison ivy/oak/sumac);
- smoking cessation;

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- vaginal products;
- wart removers;
- baldness/hair re-growth;
- dietary supplements (including botanicals/herbals, combination products, minerals, vitamins);
- deodorant/anti-perspirant products;
- diaper rash medications and diapers;
- mouthwashes/rinse;
- shampoos;
- skin bleaching;
- soap;
- sunscreens;
- toothpastes/dental floss and teeth whitening kits; and
- weight control.

Medical Equipment

- wigs, when not medically necessary for mental health;
- vacuum cleaner purchased by an individual with dust allergy; and
- mechanical exercise devices.

Vision Care

- service agreements or warranties; and
- sunglasses and sunclips.

Psychiatric Care

- psychoanalysis undertaken to satisfy curriculum requirements of a student; and
- marriage and family counseling.

Miscellaneous Charges

- Lamaze, childbirth, child education classes for preparation of childbirth;
- expenses of divorce when doctor or psychiatrist recommends divorce;
- cost of toiletries, cosmetics and sundry items (i.e., soap, toothbrushes);
- cost of special foods taken as a substitute for a regular diet;
- maternity clothes;
- diaper service;
- distilled water purchased to avoid drinking fluoridated city water supply;
- installation of power steering in an automobile;
- pajamas purchased to wear in a hospital;
- in-hospital telephone expense for personal calls, as well as calls to physician;
- insurance against loss of income, loss of life, limb or sight;
- union dues for sick benefits for members;
- contributions to state disability funds;
- auto insurance providing medical coverage to all persons injured in or by taxpayer's auto;
- the cost of weight loss programs;
- premiums for insurance coverage, warranties, service agreements for medical services and supplies;
- funeral expenses;
- expenses for nutritional supplements, vitamins, herbal supplements, and natural medicines;
- outpatient meals or lodging while receiving medical care;
- health club memberships and recreational activities;
- swimming or dancing lessons;
- custodial care, or care in a nursing home that is not medical in nature; and

FLEXIBLE SPENDING ACCOUNTS

- the cost of illegal operations, treatment or controlled substances where rendered or prescribed by licensed or unlicensed practitioners.

For a more complete list of IRS approved expenses, go to www.irs.gov under Publication 502.

Dependent Care Spending Account (DCSA)

You can contribute up to \$5,000 to the Dependent Care Spending Account. Contributions deducted from your paycheck are deposited into your account. Contributions are reported on your W-2, according to IRS rules.

In order for your Dependent Care Spending Account contributions to be treated as tax free, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's social security number. The identification number for a tax-exempt organization is its tax-exempt identification number. Your care provider should be made aware of this reporting requirement.

If you are married, you may contribute to this account only if your spouse is:

- employed outside the home;
- a full-time student at least five months of the year; or
- disabled.

Special Limits if You Are Married

These limits reflect the maximum amount of income you can deduct from your income taxes related to your Dependent Care Spending Account.

If:	Your maximum annual contribution is:
You or your spouse earn less than \$5,000	The amount the lower-paid spouse earns
Your spouse participates in a similar reimbursement plan	\$5,000 combined
You and your spouse, file separate federal income tax returns	\$2,500
Your spouse is a full-time student for at least five months of the year or is disabled	Up to \$3,000 if you have one dependent Up to \$5,000 if you have two or more dependents

Federal Child Care Tax Credit

The Federal Child Care Tax Credit is a reduction of your federal income tax for dependent care expenses. The credit is subtracted from your tax liability. Depending on your family income, the Federal Child Care Tax Credit may give you a better tax break than the Dependent Care Account. It is recommended you consult your tax advisor for guidance.

Important Note: You cannot claim the same expenses through both the Dependent Care Account and the Federal Child Care Tax Credit, and the federal tax credit is reduced, dollar-for-dollar, by amounts contributed to the Dependent Care Account.

FLEXIBLE SPENDING ACCOUNTS

Eligible Dependent Care Spending Account Expenses

Expenses eligible for reimbursement include:

- day care provided in your home by a baby-sitter, housekeeper, or relative who is not a dependent;
- day care provided outside your home, including qualified daycare providers, day camp, preschool tuition (but not kindergarten or grades above) or other outside before- and after-school programs;
- cost of transportation furnished by a dependent care provider to or from a place where the eligible dependent receives care, such as a day camp or after school program; and
- elder care for dependents that live with you.

Most types of dependent care are covered, including:

- baby-sitting in or out of your home;
- day-care centers that meet state and local laws and regulations;
- home-care specialists who care for the disabled;
- centers that care for the disabled during the day and that meet state and local laws and regulations;
- housekeepers whose services include the care of your dependent(s); and
- federal, state and local employment taxes you pay for someone you hire to provide child or eldercare for your eligible dependents.

Ineligible Dependent Care Spending Account Expenses

Among the expenses that do *not* qualify for reimbursement are but not limited to:

- expenses that are claimed as a tax credit on your income tax return;
- benefits provided to you through your spouse's employer or a government program;
- expenses for services rendered by an individual you claim as a dependent and for whom you are entitled to a personal exemption on your income tax return;
- expenses for services rendered by a child of yours under age 19, even if you do not claim the child as a dependent on your income tax return;
- babysitting when you (and your spouse) aren't at work or school;
- overnight camp;
- expense of a childcare center that provides for more than six non-resident children but does not comply with all applicable state and local laws; and
- expenses incurred while either you or your spouse, if you are married, are on a paid or unpaid leave of absence.

For a more complete list of IRS approved expenses, go to www.irs.gov under Publication 503.

Flexible Spending Account Claims

Health Care Spending Account Claims

When you enroll in the Health Care Spending Account you automatically receive a Spending Account Debit card. This card can be used to pay for out of pocket eligible expenses.

How the Debit Card Works

All employees enrolled in the Health Care Spending Account receive a Your Spending Account (YSA) Debit Card. Below are important steps to follow:

- **Save your itemized receipts** – You will be asked to submit additional documentation. If you don't provide additional documentation when it's requested, your YSA card may be suspended until the documentation is received. The documentation can be provided online, via fax or mailed. You will receive notification through the mail with a due date, however, for faster processing you should consider the online process. By going online, you can see the status of the

FLEXIBLE SPENDING ACCOUNTS

claim, when your documentation is due and you can attach the documentation and submit it online or via fax (*Tip: the only time you may not need to submit documentation would be when you use your card for prescriptions, as long as it used in an approved pharmacy*).

- **Choose “debit” or “credit” when you swipe your card-** The YSA card can be used as a PIN-based transaction if the merchant accepts them. Prior to activating the debit card, you will be requested to set up a personal identification number (PIN) associated with your card. The card can also be used as a signature-based transaction by providing your signature, as you do when you use a credit card. **Keep your account in good standing** – Only use the YSA card for eligible health care expenses at approved merchants listed on the Your Spending Account Website. Again, when requested, provide documentation to validate card purchases or services by the due date.

Log onto the Ryder BenefitsNow Portal at www.Ryder.benefitsnow.com to view your personalized Flexible Spending Account page. Go to the Health & Welfare Tab > click on Flexible Spending Accounts > scroll to the bottom of the page and click on Your Spending Account link view your home Account Summary page where you will find your balance/s, recent activity and “Take Action” section on the right side of the page to complete the reimbursement forms online or attach any receipts necessary to complete the process of any claims.

If you are unable to use your Health Care Spending Account debit card, you can submit the expense online or complete and submit a Health Care Flexible Spending Account Reimbursement Form along with acceptable evidence of your expense to the FSA Administrator. Log onto the Ryder BenefitsNow Portal at www.Ryder.benefitsnow.com to view your personalized Flexible Spending Account page. Go to the Health & Welfare Tab > click on Flexible Spending Accounts > scroll to the bottom of the page and click on Your Spending Account link> view your Account Summary page where you will find your balance/s, recent activity, and “Take Action” section on the right side of the page to complete the reimbursement forms online or attach any receipts necessary to complete the process of any claims.

The FSA Administrator will process your request and mail you a check for the maximum amount of your allowable reimbursement, up to your annual election amount. Once you have received the full amount of your FSA account election for the year, no further expenses will be reimbursed.

To be reimbursed from your Health Care Account, you need to provide acceptable evidence of the expense. Acceptable evidence includes a copy of the Explanation of Benefits (EOB) form you receive from your medical or dental benefits administrator. The EOB will show how much of your covered medical, prescription or dental expenses were denied or partially paid. You can also submit itemized bills from providers for expenses not covered by you or your spouse’s Company-sponsored health care or dental care plans. Cancelled checks or copies of checks are not acceptable evidence of an eligible healthcare expense.

The invoice or bill you submit should include the type of service or product, the date the expense was incurred, the name of the patient, the name of the provider of care or services, and the amount of the expense.

Dependent Care Spending Account Claims

Once you have an eligible expense, you may submit it for reimbursement. Bills and receipts for dependent care expenses are acceptable evidence of your dependent care expense. Each bill or receipt should show the name and address of the day care provider, the name of the dependent receiving care, the total cost of the care, and the dates of service.

How to File a Dependent Care Account Claim

To receive reimbursement, you must complete and submit a Dependent Care Flexible Spending Account Reimbursement Form along with acceptable evidence of your expense to the FSA Administrator. To submit online you go to the Ryder BenefitsNow Service Center website at www.Ryder.benefitsnow.com .

FLEXIBLE SPENDING ACCOUNTS

The FSA Administrator will process your request and mail you a check for the maximum amount of your allowable reimbursement, up to your current account balance. Once you have received the full amount of your FSA account election for the year, no further expenses will be reimbursed.

Account Statements

You will receive a yearly statement showing activity in your Flexible Spending accounts, including your account balance and reimbursements made.

Deadline for Claim Requests**Health Care Spending Account**

The Health Care Spending Account provides for a two and a half month “grace period”, so that if you don’t use the entire amount by the end of the plan year, you can use the remaining funds in the first quarter of the next plan year. This means that if you participate in the Health Care Account, you will have until March 15 of the following year to incur expenses and until April 30, of the following year to submit claims for reimbursement. You can also decide whether expenses incurred during the grace period are applied to your current year or next year’s Health Care Spending Account.

Dependent Care Spending Account

You may file Dependent Care Account claims for reimbursement through April 15 of the following year. Expenses must have occurred on or before December 31 of the previous year. For example, if you have an eligible expense on December 20, but don’t receive or pay the bill until mid-January, you may still submit the expense for reimbursement through the account. There is no grace period for the Dependent Care Spending Account.

Balances remaining in any of the spending accounts after the claim filing deadlines will be forfeited.

When you switch Medical Plans the Following Year

If you are enrolled in the Health Care Spending Account (HCSA) and decide to switch to the HSA Medical Plan for the following year, you must have a zero balance in your HCSA by 12/31 of the plan year in order to contribute any monies into your Health Savings Account.

When a Request for Reimbursement Is Denied

If a request for reimbursement is denied, you will be notified in writing. If you are not satisfied with the reason the request was denied, you may ask to have your request reviewed by the benefits administrator. For more information, see the Administrative Information section of this book.

SHORT-TERM DISABILITY

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.’s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

SHORT-TERM DISABILITY**Introduction**

The Ryder System, Inc. Short-Term Disability (STD) Plan and the Salary Continuance Plan, provides income replacement if you become disabled due to a non-work-related sickness or injury. Generally, the provisions of the Short-Term Disability and the Salary Continuance Plans are the same, unless otherwise indicated.

Benefits Administered by Liberty Mutual

Plan Features	
Type of coverage	Income replacement due to short-term disability
Basic STD Pay	Salaried employees: 100% or 60% of monthly base pay based on years of service (see grid in Salaried Employees section) Non-salaried employees*: 70% of weekly base pay up to \$325
Basic STD Coverage	Paid by the Company
Additional STD Pay (applicable only to Non-salaried employees)	70% of weekly base pay (no maximum)
Additional STD Coverage	Paid by you, with pre-tax dollars
Benefit elimination period	7 consecutive days of disability
Maximum Benefit Period	Salaried employees: 5 months All other employees: 26 weeks

* Non-salaried employees are Hourly and Field Hourly/Driver/Warehouse employees.

Definition of Disability

You are considered disabled if you have a non-occupational sickness or injury, while receiving care from a doctor on a continuing basis and you are unable to perform the material duties of your job and you have a 20% or more loss in weekly earnings due to the same sickness or injury. You must be considered actively at work the day prior to your date of disability. Actively at work means you were performing the duties of your job at your normal place of work. You will be considered actively at work while on vacation, an unrelated, approved Workers' Compensation Leave, approved Family Medical Leave of Absence or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation or holiday. An employee who is on an unpaid Personal Leave at the time of disability does not qualify for STD benefits.

For purposes of the STD Plan, "sickness" means illness, disease, pregnancy or complications of pregnancy. "Injury" means bodily impairment resulting directly from an accident and independently of all other causes.

Maternity is treated like any other sickness. Short-Term disability benefits are provided for a disability related to maternity, pre and post- delivery. Pre-delivery benefits are based on the medical evidence provided to the plan from your treating physician. Under the plan, post- delivery benefits are provided for 6 weeks for a normal, vaginal delivery or a Cesarean section.

All benefit decisions are made on the basis of medical documentation and at the sole discretion of the short-term disability insurance administrator. Ryder System, Inc. makes no determination that an employee's sickness or injury qualifies for short-term disability or salary continuance benefits under the plan.

SHORT-TERM DISABILITY

Regular Attendance and Appropriate Available Treatment

To receive benefits from the plan, you must be under the regular attendance of a physician and receiving appropriate available treatment. Regular attendance means personal visits to a physician which are medically necessary according to generally accepted medical standards to effectively manage and treat your disability. Appropriate available treatment means care or services which are:

- generally acknowledged by physicians to cure, correct, limit, treat or manage the disabling condition;
- accessible within your geographical region;
- provided by a physician who is licensed and qualified in a discipline suitable to treat the disabling injury or sickness; and
- in accordance with generally accepted medical standards of practice.

Pre-Existing Conditions

A pre-existing condition is a condition resulting from an Injury or Sickness for which medical treatment or advice was rendered, prescribed, or recommended, or medications taken, within the 3 months prior to the effective date of coverage. This plan will not cover any Disability or Partial Disability:

- which is caused or contributed to, by, or results from, a Pre-Existing Condition; and
- which begins in the first 12 months immediately after your effective date of coverage.

For Hourly/Driver/Warehouse employees, increases in Additional STD coverage are subject to pre-existing condition limitations. If benefits are not payable under newly elected Additional STD coverage, your claim will be administered as if you had not elected to increase your coverage. Your plan benefit payment would be based on the coverage level in effect before the increase in plan coverage.

Benefit Contributions During Disability

Your benefit coverage continues during an absence from work due to a disability. Your payroll contributions for all benefit elections, including 401(k) loan payments, but excluding any 401(k) contributions, will be taken from any disability payments you may be eligible to receive.

Your benefit coverage will continue while you remain disabled, or until the end of the period for which you are entitled to receive STD benefits. If your full disability benefits are paid by another source, such as a state disability insurance program, you will need to notify Ryder's Benefit department to arrange for payment of health and welfare benefits. Additionally, if your 401(k) loan payoff comes due while you are on disability leave, you must pay it off in full, otherwise the outstanding amount will be defaulted and treated as a taxable distribution.

Taxes

The Company-provided Basic STD benefit is subject to all federal, state and local taxes and withholdings including Social Security and Medicare taxes.

If you pay for Additional STD coverage, you will do so with pre-tax dollars. Under the current tax laws you will have to pay federal, state and local taxes on any Additional STD benefits paid.

Short-Term Disability Plan for Non-Salaried Employees

For Hourly Employees

Basic short-term disability provides income replacement for up to 26 weeks of disability, including the first week of disability (the plan elimination period) in which no benefit payment is issued. Ryder provides coverage at no cost to you. Benefit payments are based on a percentage of your weekly base pay. Weekly base pay excludes any overtime pay, bonuses, incentive pay or any other incentive compensation or extra income. Disability payments are based on a percentage of your weekly base pay

SHORT-TERM DISABILITY

divided by 7 calendar days. Each day is paid at 1/7 of your weekly base pay and includes Saturdays and Sundays, regardless of your work schedule.

For Field Hourly/Driver/Warehouse Employees

Basic short-term disability provides income replacement for up to 26 weeks of disability, including the first week of disability (the plan elimination period) in which no benefit payment is issued. Benefit payments are based on a percentage of your weekly base pay. Weekly base pay is the average of the last 3 months (13 weeks) of earnings starting with the most recent completed full month of work prior to the date of your disability. Base pay includes overtime, bonuses, commissions, stops, starts, and mileage. Disability payments are based on a percentage of your weekly base pay divided by 7 calendar days. Each day is paid at 1/7 of your weekly base pay and includes Saturdays and Sundays, regardless of your work schedule.

If you are disabled, recover, and become disabled again, benefits will be limited to a maximum duration of 26 weeks in any rolling 12-month period.

To be considered a new period of disability, 1 period of disability must be separated from another period of disability by a return to active full-time employment for a period of 30 consecutive days for a recurrent disability and 1 day for a new disabling condition. In the event of 2 or more periods of disability, benefits are limited to a maximum duration of 26 weeks.

Once you have received 26 weeks of STD benefits in a 12 consecutive month period, you will not be eligible to receive additional STD benefits until you have been actively at work for 6 consecutive months.

To be considered a recurrent disability, if you return to work as an active full-time employee for 30 consecutive days or more, any recurrence of a disability or a non-related disability or a disability due to the same causes as the prior disability will be treated as a new disability with respect to when benefits begin and the maximum duration of benefits provided by the plan. You will need to satisfy another 7-day elimination period before STD payments begin.

If 2 periods of the same or related disability are separated by less than 30 consecutive days of work, as an active full-time employee, the recurrent period of disability will be considered the same period of disability. A recurrent disability means a disability which is related or due to the same causes as the prior disability for which a benefit was payable. Whether the disability is considered recurrent or a new disability, the maximum duration under the plan will still apply.

The Salary Continuance Plan for Salaried Employees

Salary Continuance provides income replacement for up to 5 months of disability. Ryder provides coverage at no cost to you. Benefits are based on your monthly base pay on the date of your disability, and are not subject to increases while you are receiving benefits. Monthly base pay excludes commissions, bonuses, incentive pay or any other incentive compensation or extra income.

If you are disabled, recover, and become disabled again, benefits will be limited to a maximum duration of 5 months (up to 150 days) in any rolling 12-month period.

To be considered a new period of disability, 1 period of disability must be separated from another period of disability by a return to active full-time employment for a period of 30 consecutive days for a recurrent disability and 1 day for a new disabling condition. In the event of 2 or more periods of disability, benefits are limited to a maximum of 5 months (up to 150 days), in any consecutive 12-month period.

Once you have received 5 months of STD benefits in a 12 consecutive month period, you will not be eligible to receive additional STD benefits until you have been actively at work for 6 consecutive months.

SHORT-TERM DISABILITY

When Benefits Begin

For Non-salaried Employees

Short-Term Disability benefit payments begin after you have been disabled for 7 consecutive calendar days. The first 7 calendar days of disability (including Saturday and Sunday) are considered the elimination period, and no disability benefits are payable during this time. However, during the elimination period, pay can be made up from vacation or other paid time off programs available to you. You are limited to using only 5 days of paid time off during your elimination period.

The Basic STD plan replaces 70% of your weekly base pay to a maximum benefit payment of \$325 per week during which you are unable to perform the material duties of your job.

You may purchase additional coverage to increase your weekly maximum payment.

Type of coverage	Weekly Coverage Amount
Basic STD	70% of your weekly base pay up to a maximum of \$325 a week
Additional STD	70% of base pay (no weekly maximum)

For Salaried Employees

Salaried employees must file for salary continuance benefits after they have been disabled for 7 consecutive calendar days, which includes Saturday and Sunday. Salary Continuance benefit payments are paid retroactively to your date of disability once you have been disabled for 7 consecutive calendar days.

The Salary Continuance plan replaces a percentage of your monthly base pay on the date of your disability for up to 5 months for a non-occupational accidental injury, sickness, mental illness, pregnancy, or substance abuse. The number of months you receive 100% income replacement or 60% income replacement depends on your length of service with the Company.

The benefit you receive is based on your annual base salary.

Length of Service	Benefit Period at 100% of Salary	Benefit Period at 60% of Salary
Less than 1 year	1 month	4 months
1-5 years	3 months	2 months
5 or more years	5 months	0 months

Maternity

Maternity is treated like any other illness. Disability benefits are provided for a disability related to maternity, pre and post delivery. Pre-delivery benefits are based on the medical evidence provided to the plan from your treating physician. Under the plan, post delivery benefits are provided for 6 weeks for a normal, vaginal delivery or a Cesarean section.

Puerto Rico Employees (Hourly Employees Only)

Under the Puerto Rico Maternity Law, an employee is entitled to 8 weeks of full pay for maternity leave (4 prenatal and 4 postnatal), for the birth of a child. The employer is required to pay 100% of the employee's pay at the commencement of the maternity leave. Additionally, the employee is not eligible to apply for Puerto Rico state disability.

If the employee returns to work before the 8-week period elapses, the employee waives the remaining postpartum leave.

SHORT-TERM DISABILITY**Coordination with Other Payments**

While you are disabled, the amount of benefit you receive from the Ryder plan will be coordinated with other income benefits that you, your spouse and/or children are eligible to receive from other sources.

This includes benefits to which you or your family is eligible or that are paid to you, or to your family or to a third party on your behalf via any:

- disability and/or statutory benefits paid by the states of California, New York, New Jersey, Puerto Rico, Rhode Island, Hawaii, or other states as required by law;
- governmental law or program that provides disability or unemployment benefit as a result of your job with Ryder;
- plan or arrangement of coverage, whether insured or not, or as a result of employment by or association with Ryder or as a result of membership or association with any group, association, union, or other organization;
- individual insurance policy where the premium is wholly or partially paid by Ryder;
- the Veteran's Administration, or any other foreign or domestic governmental agency for the same disability;
- the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings;
- no fault insurance; or
- Ryder Pension Plan.

Ryder's STD benefits will be coordinated with any state (New York, New Jersey, Rhode Island, California, Puerto Rico, Hawaii, or any other state as required by law) benefits you may receive. Your Ryder benefits will be reduced by the estimated amount of the state benefits initially, and adjusted after benefits are awarded, so that the total benefit you receive from both the state and Ryder does not exceed the plan's maximum.

Disability income from any of the above sources will reduce the benefits payable from the Ryder STD plan so that your total benefit from Ryder and all other sources of disability income will equal the amount you are eligible for under this plan.

- You must inform the benefits administrator if you are entitled to, or eligible for any of these benefits. Failure to do so could cause an overpayment which will offset future benefits, until the overpayment is repaid in full.

Subrogation of Benefits

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Short Term Disability Plan and Salary Continuation Plan (STD Plans) shall be fully subrogated to and shall succeed to all rights of recovery and causes of action, under any legal theory of any type for the reasonable value of any services and benefits the Plans provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by the STD Plans and described in this Summary Plan Description, the STD Plans shall also have an independent right to be reimbursed by you for the reasonable value of any service and benefits the STD Plans provide to you, from any or all of the following listed below:

- third parties, including any person or tortfeasor alleged to have caused you to suffer injuries or damages;
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, and/or any other insurance program or from other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

SHORT-TERM DISABILITY

These responsible or potentially responsible, third parties and persons or entities are collectively referred to as "Third Parties".

By participating in the STD Plans, you agree as follows:

- that by accepting plan benefits, you consent to the plans' right to subrogation or reimbursement and consent to hold any payment, amount or recovery received from a third Party in constructive trust, lien and/or equitable lien by agreement in favor of the STD Plans;
- that you will cooperate with the STD Plans in a timely manner in protecting the STD Plans' legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - providing any relevant information requested by the Plan;
 - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
 - responding to requests for information about any accident or injuries;
 - appearing at depositions and in court;
 - obtaining the consent of the STD Plans or its agents before releasing any party from liability or payment of medical expenses, and
 - taking no action that might impair, prejudice or discharge your right to recovery or the STD Plans' right to subrogation or reimbursement;
- that failure to cooperate in this manner shall be deemed a breach of contract and may result in the termination of plan benefits and/or the institution of legal action against you;
- that the STD Plans have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
- that no court costs or attorneys' fees may be deducted from the STD Plans' recovery without the STD Plans' express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right and the STD Plans' are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue a damage/personal injury claim;
- that, regardless of whether you have been fully compensated or made whole, the STD Plans may collect from you the reasonable value of any services and benefits provided by the STD Plans, as well as collection costs, from the proceeds of any full or partial recovery that you or your legal representative obtains, whether before or after any determination of liability. The proceeds available for collection shall not be limited to only that recovery that is designated for medical costs and expenses, and shall include, but not be limited to any and all amounts earmarked as non-economic damages, settlement or judgment. The STD Plans' right to recover the proceeds is not affected by the timing of the recovery (whether before or after any determination of liability), or the manner in which the recovery is structured or worded. The STD Plans' ability to collect shall not be affected or reduced by the so-called "Make Whole Doctrine", "Fund Doctrine", "Common Fund doctrine", "Collateral Source rule", or any other equitable defenses that may affect the STD Plans' right to subrogation or reimbursement;
- that benefits paid by the STD Plans may also be considered to be benefits advanced;
- that you agree that once STD Plans' benefits are paid, a constructive trust, lien or equitable lien by agreement in favor of the plan exists with regard to any recovery, including by settlement (either before or after any determination of liability) or judgment, from a Third Party. As such, if you or your agent, including his attorney, receives any payment from any Third Party as a result of any injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you or your agent will serve as a constructive trustee and fiduciary over the funds, which will be held on behalf of the STD Plans and failure to hold such funds in trust will be deemed as a breach of your duties hereunder. Such breach may result in the termination of plan benefits or the institution of legal action against you or your agent;
- that you or an authorized agent, such as the your attorney, must hold any funds received from any Third Party that are due and owed to the STD Plans, as stated herein, separately and alone, and failure to hold funds as such will be deemed a breach of contract and may result in the termination of plan benefits or the institution of legal action against you or your authorized agent;

SHORT-TERM DISABILITY

- that the STD Plans shall be entitled to recover reasonable attorney fees from you in collecting from you any funds held by you that were recovered from any Third Party;
- that the STD Plans may set off from any future benefits otherwise allowed by the STD Plans the value of benefits paid or advanced under this section to the extent not recovered by the STD Plans;
- that you will neither accept any settlement that does not fully compensate or reimburse the STD Plans without the STD Plans' written approval, nor will you do anything to prejudice the STD Plans' rights under this section;
- that you will assign to the STD Plans all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the STD Plans provided, plus reasonable costs of collection;
- that the STD Plans' rights will be considered as a specific and first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid;
- that the STD Plans' rights will not be reduced due to your own negligence;
- that the STD Plans may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name, which does not obligate the STD Plans in any way to pay you part of any recovery the STD Plans might obtain;
- that the STD Plans shall not be obligated in any way to pursue this right independently or on your behalf;
- that you will not assign your rights to settlement or recovery against a Third Party to any other party, including their attorneys, without the STD Plans' express written consent; and
- that if the injury or condition, giving rise to subrogation or reimbursement involves the wrongful death of a STD Plans' beneficiary, this section applies to the personal representative of the deceased STD Plans' beneficiary.

Extended Disability

If your disability is extended by a new cause while you are receiving benefits from the STD plan, benefits will continue while you remain disabled. However, benefits will end once you reach the maximum duration of benefits. The plan's pre-existing limitation will apply to the new cause of disability.

Partial Disability

If you return to work on a part-time or limited basis because you are partially disabled, your benefits will be reduced by your weekly return to work earnings.

Benefits will not be reduced if your return-to-work wages are 20% or less than your adjusted pre-disability earnings. If your return-to-work wages are over 20% of your pre-disability earnings, the maximum amount you can receive in payments from work and disability benefits will not exceed 100% of your adjusted pre-disability earnings.

Workers' Compensation and Short-Term Disability

Employees on approved Workers' Compensation leave, are considered actively at work by the Plan. If, during an approved Workers' Compensation leave, you incur a non-occupational sickness or injury unrelated to your Worker' Compensation disability, which prevents you from returning to work once you are released to return to work, you may be eligible for benefits under the Ryder Short-Term Disability Plan or the Salary Continuance Plan.

If you have incurred a work-related injury or illness and have been approved for Workers' Compensation, you are not eligible for benefits through the Ryder Short-Term Disability Plan or the Salary Continuance Plan even if Workers' Compensation releases you to return to work or you have reached maximum medical improvement (MMI) and you are still unable to return to work.

SHORT-TERM DISABILITY

Important Note: If your sickness or injury prevents you from returning to work after receiving the maximum benefits under the Short-Term Disability Plan or the Salary Continuance Plan, Ryder's payroll system will update your status to administrative separation. This status update is necessary to trigger an offer of Cobra continuation for health benefits, and to allow for distribution of balances in your 401(k) Plan account. Around the time of maximum STD duration, Ryder may engage in an ADA interactive process. During this time, you may be placed on a Personal Unpaid Leave without benefits until a determination is made. You may be eligible for Long-Term Disability Benefits. Contact the Long-Term Disability Insurance Company for details regarding the Long-Term Disability Benefits that may be available to you.

Rehires and Leaves

Rehires

If you are rehired within the same calendar year, the same coverage that was in effect prior to your termination will be reinstated and no change to that coverage can be made during the rest of the calendar year. You may make changes to your coverage at the next Annual Enrollment period, for the next calendar year, subject to the plan's eligibility terms and conditions, including but not limited to pre-existing conditions and evidence of insurability rules.

If you are rehired within 24 months of your termination date, but in a different calendar year than the termination date, the salary offered to the employee in the new calendar year will be used to determine coverage amounts. Unless you have already exhausted any previous short term disability time and it would be considered successive if you were to go out on a leave of absence again.

Personal Leaves and Furloughs without Benefit

Any employee that is on a personal leave of absence or a furlough without benefits, and that (1) was previously employed with Ryder at least two month prior to the leave begin date and (2) returns to work at Ryder on a full time basis within 90 days after the leave begin date, Ryder will not apply a pre-existing condition exclusion.

In addition, for employees that were employed with Ryder less than 12 months prior to their personal leave event or furlough event, Ryder will apply the period of time worked towards the 12 month pre-existing condition period if the leave of absence is 89 days or less. Employees that return from a personal leave of absence or Furlough without benefits after 90 days will still have benefits reinstated as of the first of the month following their return to work, but they will be subject to the pre-existing condition exclusion and will not receive credit for service worked prior to the leave begin date.

If you become disabled during your Personal Leave or Furlough without benefits, you are not eligible for Short Term Disability.

What the Short-Term Disability and Salary Continuance Plans Do Not Cover

The Ryder Short-Term Disability plan does not cover disabilities caused by or related to:

- sickness or injury not being regularly attended to by a physician and not received appropriate available care;
- pre-existing conditions;
- a disability due to war, declared or undeclared, or any act of war;
- intentionally self-inflicted injuries, while sane or insane;
- a work-related accident, injury, disease or sickness (**Note:** If a claim is, or may be filed as, work related, you must sign subrogation papers stipulating your agreement to pay back to the Ryder STD plan any future money that may be awarded from an occupational sickness or injury. This agreement applies even if the claim is denied as work related);
- failure to pass DOT requirements;
- loss of commercial driving license;
- the committing of, or attempting to commit, a felony or misdemeanor;

SHORT-TERM DISABILITY

- injury sustained as a result of doing any work for pay or profit for another employer, including self-employment;
- active participation in a riot;
- cosmetic surgery unless such a surgery is in connection with an injury or sickness sustained while you are covered under this plan;
- a gender change including, but not limited to, any operation, drug therapy or any other procedure related to a gender change; and
- any period of disability during which you are incarcerated.

Ryder Short-Term Disability and Salary Continuance Plan Claims**How to Apply for Benefits**

When you expect to be disabled for more than 7 consecutive days due to a non-occupational sickness or injury, you must call the benefits administrator. Your call will put you in touch with a customer service representative who will require the following information to establish your claim:

- name and social security number;
- employer's name;
- supervisor's name and telephone number;
- physician's name, address and telephone number;
- description of your sickness or injury and your last day worked; and
- description of your job.

If your sickness or injury qualifies as a disability, the disability claim manager will call your physician to obtain medical information regarding your claim, and may call your supervisor to obtain more information about your job requirements.

When appropriate, the disability claim manager will certify the length of your disability – the length of time you will be absent from work and receiving STD benefits. You must coordinate your disability absence with your supervisor.

As a follow-up to your phone call:

- you will receive a notification from the benefits administrator stating your approved length of disability or the reason for denial;
- the benefit administrator will inform your supervisor so that he or she will know when to expect you to return to work;
- you will begin receiving disability benefit payments once your claim is approved for payment, and the benefit payment amount is received by the Ryder Payroll Department (the following deductions will continue to be taken from your disability payment: all health and welfare contributions, 401(k) loan payments, garnishments, and payroll taxes);
- a disability claims manager or physician will periodically speak with you and your physician to determine if you are progressing on schedule and, as necessary, to adjust your return-to-work date; and
- before the date on which you are expected to return to work, a disability claims manager will call you to check on your progress and confirm that you will be returning to work on the designated date.

You must coordinate safety and drug return-to-work testing with your supervisor if your disability lasts for a period of 30 days or more for safety-sensitive positions; or 90 days or more for non-safety sensitive positions.

Benefit Payments

All benefits are paid to you, beginning with the first pay cycle, after the benefits administrator's notification. Any payments owed in the event of your death may be paid to your estate.

SHORT-TERM DISABILITY

Important Note: While you are collecting benefits from the Short-Term Disability Plan or the Salary Continuance Plan, you cannot receive pay for sick, holiday or vacation days. Hourly/Driver/Warehouse employees may, however, submit any available sick, holiday or vacation time for the first 7 days – the plan elimination period – of your disability. If you receive pay for sick, holiday or vacation days during the time you are collecting benefits from the STD Plan, you may be required to reimburse Ryder for such pay.

If A Claim For Benefits Is Denied

You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed by the plan administrator. See the Administrative Information section for specific procedures to request a review of a denied claim.

Overpayments

The benefits administrator or Ryder will notify you of any overpayment of a disability claim. In this case, you must repay Ryder the amount of overpayment. Any future Short-Term Disability payments or compensation will be offset by the overpayment amount until you have repaid the full amount owed to the Company. Overpayments occur when, but not limited to:

- you do not notify or are late in notifying the benefits administrator or Ryder of your return to work;
- you receive retroactive awards from other income benefits;
- you receive more disability or continuance pay than the policy allows; or
- the benefits administrator or Ryder has made an error in calculating your benefit.

Pay Increases While Receiving Disability Benefits

You cannot receive an increase in pay if you are receiving disability benefits. Disability benefit payments are calculated and based on the plan provisions and earnings in effect on the date your disability began. Any scheduled salary increases cannot be made until the date you return to work on a regular basis, and will not be made retroactive to the date your salary was scheduled to increase.

Vacation Accrual

FMLA (Family Medical Leave Act) runs concurrently with STD. If eligible for FMLA, you will accrue vacation benefits only for the FMLA portion (12 weeks) of your STD leave. If your STD leave is longer than 12 weeks, you will not continue to accrue vacation time until you return to work. For additional information on FMLA, please refer to your Employee Handbook.

When Your Benefits End

Benefits end on the earlier of the date:

- you are no longer disabled;
- you fail to furnish adequate proof of continuing disability;
- you refuse to be examined by a physician of the plan administrator's choosing;
- you voluntarily terminate employment;
- you have received the maximum number of weeks of benefit payments;
- the plan is terminated or amended;
- your disability work earnings exceed the amounts allowed under the plan;
- you are able to return to work in a light-duty or part-time capacity and you refuse to do so;
- you are no longer under the care of a physician; or
- you are terminated for cause.

Note for employees that are terminated with severance: Termination of employment will not end approved STD benefit payments. Payments will continue even after termination of employment for as long as you remain disabled as defined by the STD Plan, but not beyond the maximum benefit period.

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

LONG-TERM DISABILITY

Introduction

The Ryder System, Inc. Long-Term Disability (LTD) Plan provides income replacement if you are unable to work because of an occupational or non-occupational sickness or injury.

LTD Summary

Benefits Insured by Liberty Mutual	
Plan Features	
Type of coverage	Income protection due to long-term disability
Basic LTD Benefit	40% of pre-disability earnings
Basic LTD Coverage	Paid by the Company
Maximum Benefit Period	Up to 24 months
Additional LTD Benefit*	50% or 60% of pre-disability earnings
Additional LTD Coverage	Paid by you, with post-tax dollars
Benefit elimination period	Salaried employees: the greater of the end of your Short-Term Disability benefit or 150 days Non-salaried** employees: the greater of the end of your Short-Term Disability benefits or 180 days
Additional LTD Maximum Benefit Period	Please refer to the tables under the Maximum Benefit Period section
Minimum monthly benefits (all options)	\$100 or 10% of your gross monthly benefits, whichever is greater
Maximum monthly benefit (all options)	\$8,000. Your LTD benefits from Ryder may be reduced by disability income you are eligible to receive from other sources such as Social Security, state disability plans, or Workers' Compensation plans.

**If you do not enroll on or before the date you first become eligible or you choose to increase your coverage due to a Qualified Life Event, you must complete and submit an Evidence of Insurability Form. The insurance carrier will make a determination of coverage, favorable or unfavorable, after reviewing the information on the Evidence of Insurability Form. If the insurance carrier has approved the increase, your new coverage amount will become effective the first of the month following the approval. In addition to the Evidence of Insurability Form, proof of good health may also include a medical exam, if requested, and additional information such as physician's statements. The Insurance carrier will pay for any additional information or tests needed to evaluate your application.*

*** Non-salaried employees are Hourly and Field Hourly/Driver/Warehouse employees.*

Definition of Disability

You are disabled when the insurance carrier determines that:

- you are limited from performing the material and substantial duties of your own occupation due to your sickness or injury;
- if you are eligible for the 24 month Own Occupation benefit, "Disability" or "Disabled" means that during the 180 day Elimination Period and the next 24 months of Disability, the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of his Own Occupation; and thereafter, the Covered Person is unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.

"Own Occupation" means the occupation you were performing when your Disability or Partial Disability began. For the purposes of determining Disability under this policy, the insurance carrier will consider your occupation as it is normally performed in the national economy.

"Any Occupation" means any occupation that you are or become reasonably suited by training, education, experience, age, physical or mental capacity.

LONG-TERM DISABILITY**Regular Attendance and Appropriate Available Treatment**

To receive benefits from the plan, you must be under the regular attendance of a physician and receiving appropriate available treatment. Regular attendance means personal visits to a physician which are medically necessary according to generally accepted medical standards to effectively manage and treat your disability. Appropriate available treatment means care or services which are:

- generally acknowledged by physicians to cure, correct, limit, treat or manage the disabling condition;
- accessible within your geographical region;
- provided by a physician who is licensed and qualified in a discipline suitable to treat the disabling injury or sickness; and
- in accordance with generally accepted medical standards of practice.

Pre-existing Conditions

A pre-existing condition is a condition resulting from an Injury or Sickness for which you were diagnosed or received Treatment within three months prior to your effective date of coverage. This plan will not cover any Disability or Partial Disability:

- which is caused or contributed to by, or results from, a Pre-Existing Condition; and
- which begins in the first 12 months immediately after your effective date of coverage.

Increases in Coverage

All increases in plan coverage are subject to the pre-existing condition provision. The pre-existing condition limitation time period will be based on the effective date of your change in coverage. If benefits are not payable under the new coverage elected because of a pre-existing condition, your claim will be administered as if you had not elected to increase your coverage.

If you do not make any changes, the Company will continue the same coverage option that you elected for the previous year, unless the current plan is no longer available.

Cost of Coverage

Premium payments for Additional LTD coverage are made through payroll deductions. Your payments for this coverage are made with post-tax deductions from your pay. Monthly premiums are based on your attained age as of December 31 of the current plan year.

Earnings are based on your base pay or previous 2-year average earnings, whichever is greater. Prior 2-year average earnings are your total earnings for the 24-month period ending August 31 of the prior plan year.

Taxes

Basic LTD plan benefits are subject to all state, local and federal taxes. Because you pay for Additional LTD coverage with post-tax dollars, under current tax law you do not have to pay regular income taxes on any Additional LTD plan benefits. You should always consult with a tax professional to verify your personal tax obligations on benefits received from the plan.

Waiver of Premium

Once you begin receiving benefits from the plan, you are no longer required to pay premiums to continue your coverage.

Your Monthly LTD Benefit

The amount and duration of your LTD benefit is based on the level of coverage you elect. Your LTD benefit is either 40%, 50% or 60% of your pre-short term disability earnings. The first 40% of monthly income replacement is paid for by Ryder and has a maximum duration of 24 months. You can choose to buy up your Long-Term Disability coverage to either 50% or 60% which would be paid by you. If you choose the additional coverage of either 50% or 60%, your LTD maximum benefit duration would be

LONG-TERM DISABILITY

extended based on the charts provided to you under the Maximum Benefit Period Section of the SPD and based on continued disability approval by the benefit administrator.

Your LTD benefit is based on the level of benefits in place in the plan year your disability began, rounded to the next higher thousand.

Pre-disability earnings is defined as the greater of:

- The average of the two years of total earnings as of August 31 of the prior year, or
- Your base pay as of August 31 of the prior year, whichever is greater.

August 31st of any given year determines the level of benefits in place as well as the premiums you will pay in the next plan year.

LTD Example: An hourly employee goes out on Short Term Disability October 3, 2016. STD maximum approval date is 26 weeks later – April 2, 2017. LTD would begin April 3, 2017. LTD benefits are based on your pre-disability earnings as of your last day worked (October 2, 2016). We look at the greater of either your average of the 2 years of total earnings as of August 31, 2015 or your base pay as of August 31, 2015 whichever is greater to determine the LTD benefit amount.

Partial Disability Benefits

You are eligible for Partial Disability Benefits if:

- you can perform one or more, but not all, of the material and substantial duties of your occupation on an active employment or part-time basis; or
- you can perform all of the material and substantial duties of your occupation on a part-time basis; and
- earn between 20% and 80% of your pre-disability earnings.

If you qualify for partial disability benefits, the plan will not offset return to work earnings for the first 12 months of partial disability benefits until the gross benefit combined with your return to work earnings exceeds 100% of your pre-disability earnings.

Benefit Maximum and Minimum

The maximum monthly benefit is \$8,000. The minimum monthly benefit is the greater of \$100 or 10% of your gross disability payment.

Recurrent Disability

You may attempt to return to work as an active full-time employee for up to 30 days during the benefit elimination period without interrupting the benefit elimination period. However, if your return to work lasts more than 30 days, it will interrupt the benefit elimination period and you will have to re-satisfy the benefit Elimination Period.

If you return to work after the benefit elimination period and are disabled again, your second disability will be considered a continuation of your first disability if:

- it has the same or related cause as your first disability, and
- it is separated by less than 6 months from your return to work.

If considered a continuation of your first disability, benefits are payable for the weeks remaining in your original benefit period. You will not have to satisfy a new elimination period.

If you return to work for 6 months or more, any recurrent disability will be treated as a new disability and is subject to the benefit elimination period and maximum period of benefits.

LONG-TERM DISABILITY**Coordination with Other Payments**

While you are disabled, the amount of benefit you receive from the plan will be reduced by other income benefits you are eligible to receive from other sources. This includes benefits to which you or your family are eligible or that are paid to you, your family, or a third party on your behalf via any:

- Workers' Compensation Law, the Jones Act, occupational disease law, Railroad Retirement act or similar governmental compulsory benefit act or law with similar intent;
- governmental law or program that provides disability or unemployment benefit as a result of your job;
- plan or arrangement of coverage, whether insured or not, or as a result of employment by or association with Ryder or as a result of membership or association with any group, association, union, or other organization;
- individual insurance policy where the premium is wholly or partially paid by Ryder;
- group insurance benefits; or
- disability and/or retirement benefits you, your spouse and/or children are eligible to receive under:
 - the United States Social Security Act;
 - the Canada Pension Plan, the Quebec Pension Plan; or
 - any other similar plan or act;
- the amount of benefits you receive under the Sponsor's Retirement Plan as follows:
 - the amount of any Disability Benefits under a Retirement Plan, or Retirement Benefits under a Retirement Plan you voluntarily elect to receive as retirement payment under Ryder's Retirement Plan; and
 - the amount you receive as retirement payments when you reach the later of age 62, or normal retirement age as defined in Ryder's plan;
 - the amount of earnings you earn or receive from any form of employment including severance; and
 - any amount you receive from any formal or informal sick leave or salary continuation plan(s).

Other Income Benefits, except retirement benefits, which may be payable as a result of the same Disability for which a benefit is paid.

The total benefit payable to you on a monthly basis (including all benefits provided under the plan) will not exceed 100% of your disability earnings.

Social Security and LTD Benefits

You are required to apply for Social Security disability benefits and any other disability income you may be eligible to receive as a result of your disability. If your initial application for Social Security is denied, you are required to follow the process established by the Social Security Administration to reconsider the denial and if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals. For information and assistance, contact the Insurance carrier. If you fail to apply for Social Security or complete the appeals process, your LTD benefits will be reduced by the estimated Social Security benefit that might have been available.

Maximum Benefit Period

The period of time LTD benefits are payable is called the maximum benefit period. Once you reach the maximum benefit period, no further LTD payments will be made. How long benefits continue generally depends on the plan you elect, your age when your disability begins, and whether you are a Salaried or Non-Salaried employee.

Basic LTD Coverage

The maximum benefit under the Basic LTD Plan is 24 months.

LONG-TERM DISABILITY**Additional 50% and 60% LTD Coverage – Non-Salaried Employees**

Age at Disability	Benefit Duration
Less than age 61	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Additional 50% and 60% LTD Coverage – Salaried Employees

The maximum period for LTD benefits depends on the age at which you become disabled and your normal retirement age:

Age at Disability	Benefit Duration
Less than age 60	To age 65, but not less than 5 years
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Combined Limit for Disabilities for Mental Illness, Substance Abuse or Non-Verifiable Symptoms

Disabilities due to sickness or injury, which are primarily due to mental illness, substance abuse, and non-verifiable symptoms, have a limited pay period of up to 24 months combined.

A mental illness means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) regardless of the underlying cause of the Mental Illness. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency.

Rehabilitation Incentive Benefits

The LTD plan supports disabled employees by providing an opportunity to be evaluated for rehabilitation. Rehabilitation is a process of working together to plan, adapt, and put into use options and services to meet your return-to-work needs. A rehabilitation program may include:

- physical therapy;
- occupational therapy;
- work hardening programs overseen by a physical therapist;
- functional capacity evaluations;
- psychological and vocational counseling;
- rehabilitative employment; and
- vocational rehabilitation services.

If you are eligible for a Rehabilitation Incentive Benefit, your monthly benefit percentage (40%, 50%, or 60%) will increase by 10%. The increased benefit will begin on the first day of the month after the insurance carrier receives written proof of your full participation in the Rehabilitation Program.

LONG-TERM DISABILITY

The Rehabilitation Incentive Benefit will cease, and your benefits will be reduced back to the elected coverage percentage, when you are no longer fully participating in the Rehabilitation Program approved by the insurance carrier or when the Rehabilitation Program ends.

What the LTD Plan Does Not Cover

The plan does not cover any disabilities caused by, contributed to, or resulting from:

- intentionally self-inflicted injuries, while sane or insane;
- active participation in a riot;
- loss of a professional license, occupational license, or certification;
- the committing of, or attempting to commit, a felony or misdemeanor;
- cosmetic surgery unless such a surgery is in connection with an injury or sickness sustained while you are covered under this plan;
- a gender change including, but not limited to, any operation, drug therapy or any other procedure related to a gender change;
- a pre-existing condition;
- a disability due to war, declared or undeclared, or any act of war; or
- any period of disability during which you are incarcerated.

Long-Term Disability Plan Claims**How to Apply for LTD Benefits**

All employees are provided Basic LTD Coverage, so there is no "application" for LTD. The insurance carrier may contact you for additional medical information at the time you transition to LTD from Short-Term Disability.

The insurance carrier may require you to provide:

- your earnings or income, including copies of your federal and state income tax returns;
- evidence that you are under the ongoing care of a physician;
- medical information, including X-ray films and copies of medical records including physical, mental, or diagnostic exams and treatment notes;
- names and addresses for all medical providers you have seen or consulted during the last three years, including physicians, hospitals, other facilities, and pharmacists;
- authorization to obtain and release your medical, employment, financial, and other information pertinent to your claim; and
- proof that you have applied for all other income benefits that are available to you.

The above information must be sent to the insurance carrier within 90 days from the day benefit payments would begin.

If no proof of loss is received by the insurance carrier by the time it is due, it will not affect the claim if it was not possible to give proof within the required time and proof is given as soon as possible, but not later than one year after it is due, unless you are not legally competent.

Proof of loss may be required throughout the duration of the claim.

Benefit Payments

All payments are made to you at the end of the month in which you are approved for LTD benefits. The insurance carrier may make an advance benefit payment based on their estimated duration of your disability. If any claim payment is due after your claim is terminated, it will be paid after you provide proof of loss to the insurance carrier.

LONG-TERM DISABILITY

Any payments at your death may be paid to your estate. If payment is owed to a minor who is not legally competent, the insurance carrier may pay up to \$3,000 to any relative who is entitled to receive the benefit.

If a monthly benefit is payable for a period of less than one month, you will be provided a benefit of 1/30 of each day you were disabled.

If a Claim for Benefits is Denied

You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed. See the Administrative Information section for specific procedures to request a review of a denied claim.

Overpayments

The insurance carrier will notify you of any overpayment of a disability claim. Overpayments may result from:

- retroactive awards from other income benefits;
- failure to report or late notification of other income benefits or earned income;
- misstatement; or
- an error made by the insurance carrier in calculating your benefit.

When Your LTD Benefits End

Your monthly benefit will end on the earliest of the following:

- the date you fail to provide proof of continued disability or partial disability and regular attendance of a physical;
- the date you fail to cooperate in the administration of the claim and such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
- the date you refuse to be examined or evaluated at a reasonable intervals;
- the date you refuse to receive appropriate available treatment;
- the date you refuse a job with Ryder where workplace modifications or accommodations were made to allow you to perform the materials and substantial duties of the job;
- the date you are able to work in your own occupation on a part-time basis, but choose not to;
- the date your current partial disability earnings exceed 80% of your indexed basic monthly earnings (these earnings will be averaged over three consecutive months);
- the date you are no longer disabled according to this plan;
- the end of the maximum benefit period; or
- the date you die.

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

LIFE INSURANCE**Introduction**

This section of your Summary Plan Description describes the Ryder System, Inc. Life Insurance Program and the Ryder System, Inc. Accidental Death and Dismemberment (AD&D) Program.

The Ryder System, Inc. Life Insurance Program

This program provides you financial protection if you or one of your dependents dies. The program includes basic life coverage. You are not required to contribute to the cost of premiums for basic life insurance. You also have the option to purchase additional life insurance for you, and dependent life insurance for your spouse, domestic partner, and/or child(ren).

The Ryder System, Inc. AD&D Program

This program provides you the option to purchase financial protection if you or a dependent are injured or die as the result of an accident.

Variations in Plan Provisions

There are some variations in coverage for employees who are covered by a collective bargaining agreement or valid written customer contract. Please refer to your collective bargaining agreement or call the Ryder BenefitsNow Service Center for information about your specific life insurance coverage.

Dual Coverage

Dual coverage is not permitted under the plan. A spouse is not eligible for coverage as a dependent if he or she is eligible as an employee. If any child qualifies as an eligible employee under the plan, he or she is not eligible to be covered as a dependent child under the Life and AD&D plans.

The Ryder System, Inc. Life and AD&D Programs

Life Insurance and AD&D are insured by Securian.

Life Insurance Highlights		
Type of coverage	Coverage Amount	Coverage paid by
Employee Basic Life*	1 x pay to a maximum of \$200,000	Ryder - you are not required to contribute to the cost of premiums
Employee Additional Life	1 x pay to 7 x pay to a combined maximum, (basic and additional), of \$1,500,000	You
Spouse Life	Increments of \$10,000 to a maximum of \$200,000	You
Child(ren) Life	\$5,000 \$10,000	You

* Life Insurance coverage amounts for Officers may vary

AD&D Highlights		
Type of coverage	Coverage Amount	Coverage paid by
Employee AD&D	1 x to 8 x pay to a maximum of \$1,500,000	You
Spouse & Child(ren)	Spouse and child(ren) are provided a percentage of the employee's coverage as follows: <ul style="list-style-type: none"> • Spouse only: 60% of the employee benefit • Child(ren) only: 20% of the employee benefit • Spouse & Child(ren): 50% spouse, 15% child(ren) of the employee benefit amount • Maximum: a maximum of \$600,000 for spouse and \$100,000 for child(ren). 	You

LIFE INSURANCE**Age Reductions**

Life Insurance coverage for Employee Basic Life Insurance, Employee Additional Life Insurance, and Spouse Life Insurance is subject to an Age Reduction Schedule.

Employee Life

When an employee reaches age 70 the life insurance coverage is reduced by 35%, and upon attainment of age 75, life insurance coverage is reduced by 50%. The reduction is taken from the amount of life insurance in effect before you reach the specified ages. The reduction will apply on January 1 of the year in which you turn 70 or 75 years of age. (For example: if you turn 70 years old on May 1, your life insurance coverage is reduced by 35% starting January 1 of the same year (five months earlier than your birthday). Premiums will be charged in accordance with the reduced level of coverage.

Spouse Life

Spouse Life Insurance coverage will be reduced based on the age of the spouse, if available. If the spouse's age is not available, spouse reductions will be based on the employee's age. Premiums for the reduced level of coverage will be adjusted accordingly.

Proof of Good Health

If you apply for an increase in coverage, you must complete and submit an Evidence of Insurability Form. After the insurance carrier has approved the increase, new coverage elected during a period of annual enrollment will become effective the later of the January 1 immediately following the enrollment period, or the date required evidence of insurability is found satisfactory, if later. Coverage elections made within 31 days of a qualified status change will become effective the later of the date of application, or the date required evidence of insurability is found satisfactory.

If you don't enroll on or before the date you become eligible for coverage and you later choose to enroll, or if you apply for more than the guaranteed issue amount, you will have to provide a completed Evidence of Insurability Form to the insurance carrier. Your coverage will begin on the first of the month following the insurance carrier's approval.

In addition to the Evidence of Insurability Form, proof of good health may also include:

- a medical exam (including bloodwork or urinalysis), if requested, and
- additional information such as physician's statements.

The insurance carrier will pay for any additional information or tests needed to evaluate your application.

Naming a Beneficiary

It is important that you designate a Beneficiary so benefits can be paid to your survivor(s) if you die. If you die, your beneficiary will receive the total amount of your Life Insurance benefits. You are the beneficiary for any dependent Life Insurance you purchase.

You can designate a beneficiary by going online to www.Ryder.BenefitsNow.com or by calling the Ryder BenefitsNow Service Center at 800-280-2999.

- to receive the death benefit, a beneficiary must be living on the date of the insured's death;
- if there is no eligible beneficiary, or if the insured does not name one, the death benefit will be paid according to the following order of priority:
 - your lawful spouse or domestic partner (includes domestic partner only if the domestic partner is registered through an affidavit on file with the policyholder); otherwise,
 - your natural or legally adopted child(ren) , if living; otherwise,
 - your parents, if living; otherwise,
 - your brothers and sisters, if living; otherwise,
 - the personal representative of the insured's estate.

LIFE INSURANCE

Cost of Coverage

You are not required to contribute toward the cost of Basic Life insurance. You have the option of purchasing, at your own expense, AD&D and Additional Life Insurance coverage as well as AD&D and Life Insurance coverage for your spouse and children. Premium payments are made through payroll deductions. Your payments for this coverage are made with post-tax deductions from your pay.

Monthly premiums for Employee Additional Life are based on the employee's attained age as of December 31 of the current plan year and the employee's total annual earnings or base pay, whichever is greater, as of August 31st of the previous year. Note: Premiums for newly hired or newly eligible employees are based on the employee's attained age as of December 31 of the current year and the employee's base pay at the time of hire. This base pay is used for the remainder of the calendar year only.

Monthly premiums for Spouse Life insurance are based on the spouse's attained age as of December 31 of the current plan year and the employee's total earnings or base pay, whichever is greater. If the spouse's date of birth is not on file, the employee's age will be used to determine the Spouse Life insurance premium.

Premiums paid for Child(ren) Life Insurance are for one or more children through attainment of age 26. If the only child covered reaches age 26, it is the employee's responsibility to drop Child(ren) Life Insurance by contacting the Ryder Benefit Service Center. If multiple children are covered, the child(ren) over age 26 are not covered, even though there is no reduction in the fixed premium.

Monthly premiums for Employee AD&D and Family AD&D are based on the employee's frozen actual annual earnings or base pay whichever is greater, as of August 31st of the previous year. Premiums for newly hired or newly eligible employees are based on the employee's base pay.

Imputed Income

According to federal tax law, up to the first \$50,000 of employee basic life insurance is available tax-free. You pay taxes on the value (as determined by the IRS) of basic life insurance coverage over \$50,000. The IRS determined value of coverage over \$50,000 is commonly called imputed income and is added to your taxable pay.

You must contact the Ryder BenefitsNow Service Center to drop Spouse Life, Child Life and Family AD&D insurance coverage on ineligible dependents, within 30 days of the date they became ineligible. Benefits under the Life and AD&D insurance plans are not payable to you, if your dependents are deemed ineligible, regardless if you were paying the monthly premiums.

Coverage Continuation through Portability or Conversion

If your coverage ends, you may be eligible to continue some or all of your insurance coverage on a direct-billed basis under either the portability or conversion options of the group policy. The chart below compares these options. Generally speaking, portability premiums are slightly higher than active premium rates, but less than conversion rates. Rates increase with age and are subject to change. In order to continue coverage, you must complete an election form and send it to Securian within 31 days of the date the coverage would otherwise have terminated. All coverage continued through portability or conversion is continued without proof of good health. Contact Securian at 866-293-6047 to learn more about the portability and conversion options. You will be provided with rate information and an application upon request.

Life Insurance Payout If You Die

The payable amount of both Life Insurance and AD&D Insurance is based on the employee's total annual earnings or base pay, whichever is greater, as of August 31st of the prior year. That coverage volume is the payable amount in the event of a death or covered AD&D injury for the subsequent calendar year. Any changes to earnings from and after August 31st of the prior year will not be included as part of any life

LIFE INSURANCE

insurance payout for the next calendar year. Policy volumes will be updated each upcoming calendar year based on covered earnings as of the prior August 31st. Note: Policy death benefits for a newly hired or newly eligible employee are based on the employee's base pay.

Life insurance and AD&D insurance coverage amounts for employees classified as Officers may vary.

	Portability	Conversion
Eligible coverage	<ul style="list-style-type: none"> ▪ Basic and Additional Term Life and Voluntary AD&D coverage can be ported. ▪ Dependent coverage can only be ported if employee coverage is ported. 	<ul style="list-style-type: none"> ▪ All Basic and Additional Term Life coverage can be converted. ▪ AD&D coverage cannot be converted
Events allowing portability/conversion	Coverage is lost due to: <ul style="list-style-type: none"> ▪ Retirement ▪ Termination of employment ▪ Layoff or non-medical leave ▪ Other loss of eligibility 	Coverage is lost due to: <ul style="list-style-type: none"> ▪ Retirement ▪ Termination of employment ▪ Layoff or leave ▪ Loss of eligibility ▪ Termination of group policy ▪ Medical leave ▪ Exhausting STD
Maximum age to elect	Employee: Age 69 Spouse/DP: Employee's age 69 Child: Qualifying age or employee's age 69	No maximum age
Minimum amount allowed	Employee: \$10,000 Spouse/DP: \$1000 Child: \$1000	No minimum
Maximum amount allowed	Employee: Previous amount in force to maximum of \$750,000 (65% of previous amount to maximum of \$487,500 if 65 or older) Spouse/DP: Previous amount in force to a maximum of \$150,000 Child: Previous amount in force	Previous amount in force unless conversion is due to policy or class termination. If conversion is due to policy/class termination, maximum is the lesser of \$10,000 or the existing coverage amount less the new coverage amount available under group replacement policy.
Age reductions	Employee coverage reduces to 65% at age 65.	No age reductions
Termination age	Employee: Age 70 Spouse/DP: Employee's age 70 Child: Qualifying age limit or employee's age 70	No termination age

LIFE INSURANCE**AD&D Benefit Schedule**

If You Lose:	You or Your Beneficiary(ies) Will Receive:
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
One foot and sight of one eye	100%
One hand and sight of one eye	100%
Speech and hearing in both ears	100%
Quadriplegia	100%
Triplegia	75%
Paraplegia & Hemiplegia	50%
Uniplegia	25%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Thumb and index finger of the same hand	25%

No more than 100% of your AD&D coverage will be paid for all losses resulting from one accident.

Coma Benefit

The plan will pay a benefit if an insured sustains an injury which, independent of all other causes, directly results in the insured being in a coma. The benefit will be paid at the rate of 1% per month for a maximum of 100 months. The waiting period for the Coma Benefit is 31 days from the date you become comatose during which time no Coma Benefits are payable. Payment of this benefit will reduce the insured's total AD&D benefit.

Brain Damage Benefit

The plan will pay 50% of the coverage, limited to brain damage that lasts at least 12 consecutive months or more and is permanent and irreversible and began within 60 days of injury.

Exposure

The plan will provide coverage if you sustain an injury and you are unavoidably exposed to the elements and suffer a loss as a result of the exposure.

Disappearance

The plan will presume an insured suffered loss of life due to an accident if an insured's body is not found within one year of the accident in which the conveyance an insured was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked.

Spouse Education /Training Benefit

If the insurance carrier approves your claim and receives proof that you have died as the result of an injury, the plan will pay the actual cost incurred by your spouse or domestic partner for full-time enrollment in and accredited professional institution or an institution of vocational training for the purpose of preparing for full-time employment. Enrollment must occur within 365 days from the date of the accident that caused the injury. The plan will pay a maximum benefit of the lesser of:

- 10% of the paid AD&D benefit; or
- \$20,000; or
- costs incurred within the 30-month period following the date of the accident.

Child Education Benefit

If the insurance carrier approves your claim, the plan will pay your authorized representative, on behalf of each of your Qualified Children, an Education Benefit if you die as a result of injury.

Benefits will be paid for each dependent, provided that at the time of the death, the dependent child is enrolled as a full-time student at an accredited post-secondary educational institution and is under age 23. The annual benefit payable will be paid for up to four consecutive years, at the lesser of:

- 10% of the paid AD&D benefit;
- \$20,000;
- actual education costs incurred.

Child Care Benefit

If the insurance carrier approves your claim, the plan will pay your authorized representative an additional benefit for childcare if you sustain an injury, which causes your death. Childcare expenses are those expenses that are for a service or supply furnished by a licensed childcare provider or facility for a dependent child's care. No payment will be made for expenses incurred more than four years after the date of your death.

Charges will be reimbursed for each eligible dependent child (birth to age 13) up to a maximum of the lesser of:

- 5% of the paid AD&D benefit; or
- \$7,500; or
- Incurred childcare expenses per year.

The total maximum benefit amount payable is \$30,000, regardless of the number of children who qualify.

If You Become Terminally Ill

If you have a life expectancy of 12 months or less, you can request an accelerated death benefit from your basic and additional life insurance plans. Similarly, if your insured dependent has a life expectancy of 12 months or less, you can request an accelerated death benefit from the dependent life insurance plan. To qualify for an accelerated benefit, you or your covered dependent must:

- be insured for at least \$10,000;
- have not assigned ownership rights under the coverage;
- not have an irrevocable beneficiary; and
- be terminally ill (life expectancy of 12 months or less).

If you qualify, you may choose a full or a partial accelerated benefit. A partial benefit can only be requested if the remaining amount after the early payout is at least \$25,000. If a partial benefit is chosen, coverage will remain in force and the amount remaining will be the full amount prior to the early payout minus the amount that was accelerated. If a full benefit is paid, the coverage will end. If your employee life coverage ends due to taking a full benefit, then any coverage on your dependents will also end at that time, though they will have the right to convert life insurance coverage to an individual policy.

An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the insured:

- is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
- is required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

The maximum amount that can be accelerated is \$1 million.

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Seat Belt/Safety Net Benefit

If you die from injuries sustained in a motor vehicle accident, a seat belt/safety net benefit will be paid in addition to the life insurance benefit if:

- the injury occurs where you were a passenger in a private passenger car or tractor trailer, were not intoxicated, impaired or under the influence of alcohol or drugs and
- you were wearing a seat belt or safety net at the time of the accident (as verified by a police accident report).

The seat belt/safety net benefit payable is the lesser of:

- one times your annual base pay, or
- \$25,000.

Motorcycle Helmet Benefit

If you die from injuries sustained while driving or riding on a motorcycle, a motorcycle helmet benefit will be paid in addition to the life insurance benefit if:

- the injury occurs where you were a passenger or driving a registered motorcycle, were not intoxicated, impaired or under the influence of alcohol or drugs and
- you were wearing a motorcycle helmet at the time of the accident (as verified by a police accident report).

The Motorcycle Helmet benefit payable is the lesser of one times your annual base pay or \$25,000.

What the Life Insurance Programs Do Not Cover

Basic Life Insurance

There are no exclusions applicable to Basic Life Insurance.

Additional Life Insurance and Spouse Life Insurance

Additional Life Insurance and Spouse Life Insurance are subject to suicide exclusion. No benefit is payable if death results from suicide, whether the individual is sane or insane, within two years of the effective date of coverage. Additionally, if death does result from suicide, whether the individual is sane or insane, within two years of the effective date of an increase in coverage, the death benefit payable is limited to the amount of coverage effective before the increase.

What the Employee and Dependent AD&D Program Does Not Cover

The AD&D program will not pay for losses resulting from: (This list is not intended to be all inclusive)

- suicide or attempted suicide, whether sane or insane; or
- intentionally self-inflicted injury or any attempt at self-inflicted injury, whether sane or insane; or
- the covered person's participation in, or attempt to commit, a crime, assault or felony; or
- bodily or mental infirmity, illness or disease; or
- medical or surgical treatment including diagnostic procedures; or
- alcohol, drugs, poisons, gases or fumes, voluntarily taken, administered, absorbed, inhaled, ingested or injected; or
- bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury; or
- travel or flight in or on any vehicle used for aerial navigation including getting in, out, on, or off such vehicle, if the covered person is:
 - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - acting as a pilot or a crew member of any aircraft, unless riding as a passenger; or
 - riding as a passenger in a non-chartered aircraft which is owned, leased, operated, or

- controlled by Ryder; or
 - a student taking a flying lesson, unless riding as a passenger; or
 - hang gliding; or
 - parachuting, except when the insured has to make a parachute jump for self-preservation; or
- war or any act of war, whether declared or undeclared; or
- riot or civil insurrection ; or
- service in the military of any nation.

Ryder Life Insurance and AD&D Claims

How to Apply for Life Insurance and AD&D Benefits

To initiate a claim for life or AD&D insurance benefits, contact the Ryder BenefitsNow Service Center at 800-280-2999 to report the death or accident. The Ryder BenefitsNow Service Center will initiate the claim with Securian. Securian will contact the beneficiary(ies) or the executor of the estate to request the necessary documents (i.e., certified copy of the death certificate, accident report, etc.).

Benefits are paid in a lump sum to your designated beneficiary. If more than one beneficiary is named, each will be paid an equal share or as specified on your beneficiary form. If any named beneficiary dies before you, his or her share will be divided equally among the named surviving beneficiaries. Benefit payments should be exempt from federal income taxes.

If a minor does not have a legal guardian, payment may be made to the person caring for and supporting him or her until a legal guardian is appointed.

If a Claim for Benefits is Denied

You will be notified in writing if a claim for benefits is denied. If you are not satisfied with the reasons for the denial, you may ask to have the claim reviewed. See the Administrative Information section for specific procedures to request a review of a denied claim.

Business Travel Accident

The Business Travel Accident Plan provides added protection for active full-time employees traveling on Company business except for regular commuting to and from work. The plan provides a death benefit in the case of accidental death, an accidental dismemberment benefit for the loss of limb (or use of limb), sight, speech or hearing or a lump sum disability benefit if permanently disabled as a result of an accident.

All active full-time employees are eligible for this coverage on their date of hire as follows:

- hourly and salaried employees are eligible for up to 2x base pay to a maximum of \$300,000;
- Drivers are eligible for up to 1x base pay to a maximum of \$100,000. Coverage is applicable to drivers traveling on business during a bonafide trip other than in the course of their regular employment; and
- employees MS Level 14 and above are eligible for up to 3x base pay to a maximum of \$1,500,000.

The plan provides the following benefits for spouse/domestic partner and dependent child(ren) of the employee groups above, if invited to travel at Ryder's expense:

- Spouse/Domestic Partner - \$25,000;
- Child(ren) - \$10,000.

HYATT LEGAL PLAN

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

Introduction

This section describes how the Hyatt Legal Plan works.

How The Program Works

The Hyatt Legal Plan offers a national network of attorneys to provide certain personal legal services and counsel at no cost or reduced cost. Attorney fees for representation covered by the Plan are fully paid by the Plan when you see a Plan Attorney. You may choose coverage for yourself only, or for your entire family. With family coverage, your spouse and dependents are also eligible for most services.

The Plan offers advice and consultation on certain personal legal matters, as well as representation for many other personal legal matters such as uncontested separation and divorce, custody issues, tax audits, boundary disputes, etc.

How to Enroll

If you are a U. S. based employee, you may elect coverage in the Hyatt Legal Program during your new hire enrollment or at Annual Enrollment each fall. There are two coverage categories: *Employee Only* or *Family Coverage*, which provides coverage for your spouse and dependents under age 26.

Once you enroll, you cannot change or cancel your coverage until the next Annual Enrollment period. If you experience a Qualified Life Event during the year that impacts your dependent situation, you may change your coverage in a manner consistent with the Qualified Life Event (for example, if you are enrolled in individual coverage and marry, you may change your coverage to family). However, you cannot cancel the coverage because of a Qualified Life Event.

Covered Services

Advice and Consultation

- Office Consultation and Telephone Advice. This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Consumer Protection

- Consumer Protection Matters. This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.
- Personal Property Protection. This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.
- Small Claims Assistance. This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence,

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documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Debt Matters

- **Debt Collection Defense.** This service provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.
- **Identity Theft Defense.** This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.
- **Identity Management Services.** This service provides the Participant with access to LifeStages Identity Management Services provided by CyberScout, formerly known as IDT911, LLC. These services include both Proactive Services when the Participant believes their personal data has been compromised as well as Resolution Services to assist the Participant in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft Support, Fraud Support, Recovery and Replacement services are covered by this service. For more information on identity theft protection, please visit <http://www.legalplans-idtheft.com/>.
- **Tax Audits.** This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

Defense of Civil Lawsuits

- **Administrative Hearing Representation.** This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.
- **Civil Litigation Defense.** This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.
- **Incompetency Defense.** This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

Document Preparation

- Affidavits. This service covers preparation of any affidavit in which the Participant is the person making the statement.
- Deeds. This service covers the preparation of any deed for which the Participant is either the grantor or grantee.
- Demand Letters. This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.
- Document Review. This service covers the review of any personal legal document of the Participant such as letters, leases or purchase agreements.
- Elder Law Matters. This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills and wills. The service also includes preparing deeds for the parents when the Participant is either the grantor or grantee; and preparing promissory notes for the parents when the Participant is the payor or payee.
- Mortgages. This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.
- Promissory Notes. This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Family Law

- Adoption and Legitimization (Contested and Uncontested). This service covers all legal services and court work in a state or federal court for an adoption for the Plan Member and spouse. Legitimization of a child for the Plan Member and spouse, including reformation of a birth certificate, is also covered.
- Divorce, Dissolution and Annulment (Uncontested). This service is available to the Plan Member only, not to a spouse or dependents, and only applies as long as the spouse does not hire an attorney or file a responsive pleading that contests any portion of the case. This service includes preparing and filing all necessary pleadings and affidavits, drafting settlement or separation agreements and representation at an uncontested hearing. If a case is contested, the Plan Member must pay all legal fees. This service cannot be used as a "credit" toward a contested case. This service does not include disputes that arise after a decree is issued.
- Name Change. This service covers the Participant for all necessary pleadings and court hearings for a legal name change.
- Prenuptial Agreement. This service covers representation of the Plan Member and includes negotiation, preparation, review and execution of a Prenuptial Agreement between the Plan Member and his or her fiancé/partner prior to their marriage or legal union (where allowed by law). It does not include subsequent litigation arising out of a prenuptial agreement. The fiancé/partner must have separate counsel or waive his/her right to representation.
- Protection from Domestic Violence. This service covers the Plan Member only, not the spouse or dependents, as the victim of domestic violence. It provides the Plan Member with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action or representation for the offender.
- Uncontested Change or Establishment of Custody Order. This service is available to the Plan Member and spouse, and covers preparation of petitions, consent forms and waivers, and representation at any court hearings provided all parties are in agreement to establish or modify a child custody order.

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- **Uncontested Guardianship or Conservatorship.** This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the Plan Member or spouse is being appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. If the proceeding becomes contested, the Plan Member or spouse must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

Immigration Assistance

- This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

Insurance Matters

- **Insurance Claims.** This service provides the Participant with assistance in making insurance claims with the Participant's own carrier, provided the carrier is not affiliated with the Plan Member's Sponsor or Employer. Litigation of coverage issues is included. Litigation of damages is not included.

Personal Injury

- **Personal Injury (25% Network Maximum).** Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

Real Estate Matters

- **Boundary or Title Disputes (Primary Residence).** This service covers negotiations and litigation arising from boundary or real property title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.
- **Eviction and Tenant Problems (Primary Residence - Tenant Only).** This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.
- **Home Equity Loans (Primary Residence).** This service covers the review or preparation of a home equity loan on the Participant's primary residence.
- **Home Equity Loans (Second or Vacation Home).** This service covers the review or preparation of a home equity loan on the Participant's second or vacation home.
- **Property Tax Assessment (Primary Residence).** This service covers the Participant for review and advice on a property tax assessment on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.
- **Refinancing of Home (Primary Residence).** This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage, and deed and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, or property that is held for any rental, business, investment or income purpose.

Refinancing of Home (Second or Vacation Home). This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's second home or vacation home. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.

- Sale or Purchase of Home (Primary Residence). This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.
- Sale or Purchase of Home (Second or Vacation Home). This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's second home, vacation home or of a vacant property to be used for building a second home or vacation home. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.
- Security Deposit Assistance (Primary Residence – Tenant only). This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant's residential landlord for the Participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. This service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.
- Zoning Applications. This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

Traffic and Criminal Matters

- Expungement. Where permitted by law, this service covers the filing of a petition and appearance at any necessary hearing to expunge convictions from a Participant's criminal record.
- Juvenile Court Defense. This service covers the defense of a Participant and a Participant's dependent child in any juvenile court matter, provided there is no conflict of interest between the Participant and the dependent child. When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the Plan Member only, including services for Parental Responsibility.
- Restoration of Driving Privileges. This service covers the Participant with representation in proceedings to restore the Participant's driving license.

HYATT LEGAL PLAN

- Traffic Ticket Defense (No DUI). This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Wills and Estate Matters

- Living Wills. This service covers the preparation of a living will for the Participant.
- Powers of Attorney. This service covers the preparation of any power of attorney when the Participant is granting the power.
- Probate (10% Network Discount). Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.
- Trusts. This service covers the preparation of revocable and irrevocable trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.
- Wills and Codicils. This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

What Is Not Covered - Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment related matters, including Company and statutory benefits;
- Matters involving Company, MetLife and affiliates, and Plan Attorneys;
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents;
- Appeals and class actions;
- Farm matters, business or investment matters, matters involving property held for investment or rentals, or issues when the Participant is the landlord;
- Patent, trademark and copyright matters;
- Costs or fines;
- Frivolous or unethical matters;
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits.

How the Hyatt Legal Plan Works

To use the plan, Participants should log on to www.legalplans.com or call the Hyatt Legal Plans' Client Service Center at 800-821-6400, Monday through Friday, from 8:00 a.m. to 7:00 p.m. Eastern time.

If you use Hyatt's web site at www.legalplans.com, click "Members Log In."

If you call the Client Service Center, the Client Service Representative who answers your call will:

- verify your eligibility for services;
- make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- give you a Case Number that is similar to a claim number (you will need a new Case Number for each new case you have);
- give you the telephone number of the Plan Attorney most convenient to you; and
- answer any questions you have about your Legal Plan.

Then call the Plan Attorney and identify yourself as a legal plan member referred to them by Hyatt Legal Plans. You should request an appointment for a consultation. You should be prepared to give them your Case Number, the name of the legal plan you belong to and the type of legal matter you are calling about. Evening and Saturday appointments are available. If you wish, you may choose an out-of-network

attorney. In a few areas, where there are no Participating Law Firms, you will be asked to select your own attorney. In both circumstances, Hyatt Legal Plans will reimburse you for these non-Plan attorneys' fees based on a set fee schedule.

How Services Are Paid

The legal plan offers a national network of attorneys to provide certain services and counsel at little or no cost.

- **In-Network:** When you use a Hyatt Legal Plan attorney, attorney fees for covered services are paid in full, and there are no claim forms to file.
- **Out-of-Network:** You may choose an attorney who is not part of the Hyatt network. If you choose an out-of-network attorney, you may be reimbursed according to a set fee schedule.

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

THIS SECTION OF THE BENEFITS SUMMARY CONSTITUTES PART OF A PROSPECTUS COVERING SECURITIES THAT HAVE BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933.

401(k) SAVINGS PLAN

Introduction

Ryder System, Inc. (also known as "Ryder" or the "Company") established the Ryder System, Inc. 401(k) Savings Plan (the "401(k) Plan") effective January 1, 1993. The 401(k) Plan offers you a valuable, tax-advantaged savings tool to invest for your future financial security. The combination of convenient pre-tax and post-tax contributions (including Roth contributions), Company contributions and a variety of investment choices makes the 401(k) Plan an excellent long-term savings vehicle.

The 401(k) Plan is a defined contribution plan meeting the requirements of section 401(k) of the Internal Revenue Code and section 404(c) of ERISA.

Note: employees of Ryder Puerto Rico, Inc. are eligible to participate in the Ryder Puerto Rico, Inc. Employees' Savings Plan. A summary of that plan will be sent under separate cover to employees working in Puerto Rico. The information contained in this section applies to employees working and residing in the United States only.

Eligibility

You are eligible to participate in the 401(k) Plan as of the first of the month following 6 months of employment with Ryder if you are an employee of Ryder System, Inc. or any of its subsidiaries or affiliates that have elected to offer the 401(k) Plan to certain employee groups. Deductions begin with the first paycheck in which all earnings are from the month in which that paycheck falls.

You are eligible to receive Company contributions on the first of the month after the later of the date you have completed one year of service in which you have worked at least 1,000 hours or attained age 21.

You may not participate in the 401(k) Plan if you are (1) designated by Ryder as an independent contractor and not on Ryder's U.S. payroll (regardless of your employment status under the law) at the time of any determination, or (2) being paid by or through an employee leasing company or other third party agency.

Union Employees

If you work under the provisions of a collective bargaining agreement, you are eligible to participate *only* if your agreement specifically provides for benefits under the 401(k) Plan.

Re-employment

If you leave the Company after meeting the eligibility requirements of the 401(k) Plan and are later rehired, you will be immediately eligible to re-enroll in the 401(k) Plan.

If you leave the Company before you are fully vested in the 401(k) Plan and you are re-employed by the Company within 5 years following the date of your termination, forfeited Company contributions will be restored to your account. You must notify the Ryder Retirement Service Center in writing of your re-employment.

If you were fully vested in the 401(k) Plan when you left Ryder, all future Company contributions will be fully vested as well.

Enrollment

You will receive an enrollment package some time before the end of your six-month waiting period. Once you receive 401(k) Plan materials, you may enroll in the 401(k) Plan. Your contributions to the 401(k) Plan will begin following your waiting period.

401(k) SAVINGS PLAN

You can enroll in the 401(k) Plan:

- Online at <http://netbenefits.fidelity.com>, or
- By calling the Ryder Retirement Service Center at 800-373-7300.

When you enroll in the 401(k) Plan, you must decide:

- The percentage of your annual earnings you want to save or contribute to the 401(k), and
- How you want to invest your contributions.

Break in Service

You have a break in service if you don't complete at least one hour of employment in a specific one-year period.

If your break in service is because of your pregnancy, the birth of your child, the placement of a child for adoption by you, or for you to care for the child right after the birth or placement for adoption, the first two years of your absence will not count as breaks in service.

If your break in service is due to an unpaid FMLA leave, you will receive credit for the period you are on leave, only for purposes of determining if you have a break in service.

If you have 5 consecutive breaks-in-service (or if you have a break-in-service equal to the period of service you earned before you separated from service, if longer), then once again become eligible to participate in the 401(k) Plan, your service before the breaks will not be counted for purposes of determining your vested interest in Company contributions if (1) you had not made pre-tax or Roth contributions to the 401(k), and (2) you had no vested interest in any Company contributions that may have been made on your behalf prior to your breaks.

Your Personal Identification Number (PIN)

To access account information online or over the phone, you will need a personal identification number (PIN). To create your PIN:

- Go to <http://netbenefits.fidelity.com> and click on "Access My Benefits" in the NetBenefits box. Click on "New User Registration" and follow the instructions, or
- Call the Ryder Retirement Service Center at 800-373-7300 and follow the instructions.

When Participation Begins

For purposes of making pre-tax and post-tax (including Roth) contributions, you become a participant on the latest of the first day you meet eligibility requirements, the day you enroll in the 401(k) Plan, or the first day of the month on or after you complete six months of employment. For purposes of receiving Company contributions, you become a participant on the first day of the month on or after the latest of the first day you meet eligibility requirements, the day you complete one year of service in which you have worked at least 1,000 hours, and/or you attain age 21.

Naming a Beneficiary

When you enroll in the 401(k) Plan, you must name a beneficiary. Your beneficiary is the person who will receive any account balance remaining at the time of your death. Your beneficiary can be a trust, estate, charity, or a person.

- If you are married, according to IRS regulations, your spouse is the named beneficiary.
- To name a beneficiary other than your spouse, you and your spouse will have to complete a beneficiary designation form. A notary must witness your spouse's signature consenting to the change.
- If you do not have a completed form on file or your beneficiary dies before you, your account balance will be paid to the beneficiary (or beneficiaries) you named under the Company's group life insurance plan. If you did not name beneficiaries under that program or if he, she or they die before you, your account balance will be paid as follows:

401(k) SAVINGS PLAN

- to your spouse,
- if no spouse exists, to your children,
- if no children exist, to your estate.

Making Changes During the Year

You may increase, decrease or stop your contributions to the 401(k) Plan at any time. You may also change how your account is invested at any time. This includes changing the way future savings are invested or reallocating or transferring funds already in your account.

To change your contributions or change how your contributions are invested, call the Ryder Retirement Service Center at 800-373-7300 or go online to <http://netbenefits.fidelity.com>. Investment changes received by 4:00 p.m. Eastern Time will be effective at the closing price on that business day.

Changes you make to your contribution rate become effective as soon as administratively possible. You will receive a written confirmation statement within three to five business days of making a change to your contributions or investment mix.

Plan Highlights

Plan Features:	
Participation	Upon enrollment after becoming eligible.
Your Contributions	<p>You are eligible to contribute on and after the first of the month following six (6) months of service and with the first paycheck in which all earnings are from that month.</p> <p>The maximum the IRS allows you to contribute on a pre-tax and/or Roth basis is \$18,500 in 2018. You can contribute an additional amount on a post-tax basis up to a maximum of 50% of your annual earnings.</p> <p>Employees defined by the IRS as "highly compensated" are limited to a combined pre-tax and post-tax (including Roth) contribution maximum of 6%.</p>
Catch-up Contributions	If you are age 50 or over, you can contribute up to an additional \$6,000 in pre-tax and/or Roth dollars after you have reached the IRS maximum of \$18,500 in 2018.
Investment options	You can invest your account among the investment funds offered.
Vesting	<p>You are always 100% vested in your own contributions.</p> <p>You become 100% vested in any Company contributions when you complete 5 years of service with the Company</p>
Loans	<p>You may have up to two outstanding loans limited to:</p> <ul style="list-style-type: none"> • One General Purpose Loan- maximum term up to 5 years, and/or • One Home Purchase Loan- maximum term up to 15 years.
Withdrawals	You may withdraw money from your account. Special rules apply.
You can take your money with you.	If you leave the Company before you retire, you can rollover your vested account balance into an eligible rollover plan (defined below under the section entitled "Rollovers").

401(k) SAVINGS PLAN**How the 401(k) Plan Works**

- The 401(k) Plan lets you contribute part of your annual earnings (your pay) – from 1% to 50% on a combined pre-tax or post-tax (including Roth) basis into the 401(k) Plan. Pre-tax and Roth contributions are subject to annual IRS limits. The percentage of your pay you decide to contribute is automatically deducted from your pay each pay period. Highly compensated employees may be limited in the amount they can contribute to the 401(k) Plan and may receive a refund of a portion of their annual contribution election if the 401(k) Plan does not meet IRS discrimination testing guidelines.
- You may elect that all or any portion of your pre-tax contributions are designated as Roth contributions. You can modify this election any time, but any modification will apply to future contributions only.
- The amount of your pre-tax contributions to the 401(k) Plan is not taxed as income. Because your contribution is made before income taxes are calculated, your taxable pay is less, which reduces your taxes.
- The amount of your post-tax and Roth contributions is taxed as income. Because your contribution is made after taxes are calculated, your taxable pay is not reduced by the amount of your contribution.
- You won't owe federal income tax on your pre-tax contributions or their earnings until they are withdrawn from the 401(k) Plan. Your earnings are allowed to remain in your account and grow on a tax-deferred basis until you take your money out of the 401(k) Plan.
- You won't owe federal income tax on your post-tax contributions, even when they are withdrawn from the 401(k) Plan. However, any earnings made on your post-tax contributions are subject to federal income tax when they are withdrawn from the 401(k) Plan. Your earnings are allowed to remain in your account and grow on a tax-deferred basis until you withdraw them from the 401(k) Plan.
- You won't owe federal income tax on your Roth contributions, even when they are withdrawn from the 401(k) Plan. In addition, you won't owe federal income tax on earnings made on your Roth contributions when they are withdrawn from the 401(k) Plan if the withdrawal is a "qualified distribution," that is, it occurs on or after the date you attain age 59-1/2 or the date you become disabled, and at least 5 years after the date you first made Roth contributions or a Roth rollover to the 401(k) Plan. Company contributions and earnings on Company contributions attributable to Roth deferrals are taxable upon withdrawal.
- You can borrow up to 50% of your vested account balance, up to a maximum of \$50,000, reduced by the difference between your highest balance over the last 12 months of any outstanding loan against your account and the balance of any outstanding loan on the date you make this loan. The interest you pay goes back into your account, so you pay yourself back rather than a bank or credit company. Interest rates for loans are based on the prime rate in effect when you request a loan. You are limited to a maximum of two outstanding loans, a general-purpose loan and a loan to purchase or construct your primary residence. You may not have two general-purpose loans.
- There is a 30-day waiting period before a participant may request a new loan after an existing loan has been fully paid off.
- You can tailor your investment strategy to meet your financial goals and risk preference. The 401(k) Plan has several investment options to help you build your retirement savings. These funds represent a range of investment categories – stocks, bonds and money market securities.
- Your investment earnings in the 401(k) Plan grow tax-free until your retirement. However, except in the case of a qualified distribution from your Roth account, you must pay taxes when the earnings are paid out, unless you transfer your account to an eligible rollover plan (defined below under the section entitled "Rollovers").

401(k) SAVINGS PLAN

Saving With Tax-Deferred Contributions

Your pre-tax contributions are deducted from your pay before federal and most state and local income taxes are calculated. Your pre-tax contributions are subject to Social Security and certain other employment taxes.

Your post-tax contributions are deducted from your pay after federal, Social Security, and most state and local income taxes are calculated.

Limits on Contributions

Current federal laws limit the amount you can contribute on a pre-tax basis to the 401(k) Plan.

- **Pre-tax and Roth contribution limit** – This limit on your combined pre-tax and Roth contributions may be adjusted each year to keep pace with the cost of living. For 2018, the limit is \$18,500, excluding catch-up contributions. This limit includes all pre-tax and Roth contributions that you make to all qualified plans in which you participate during any given taxable (usually calendar) year.
- **Highly compensated employee limit** – The IRS rules also limit the amount that highly compensated employees can contribute to the 401(k) Plan. These amounts are determined as a result of the application of IRS discrimination tests. If you earned \$120,000 or more in 2017 (and were among the top-paid 20% of employees in 2017), you are considered a highly compensated employee for the 2018 plan year. As a result, the 401(k) Plan may return to you amounts you deferred that exceed the amounts permitted, as determined under these tests.
- **The Section 415 limit** – This is a limit on the total annual amount of employee contributions and Company contributions that may be made to the 401(k) Plan. The limit is \$55,000, excluding catch-up contributions. This limit may change periodically. If your combined contributions exceed this limit, you'll be notified.
- **Compensation limit** – Under IRS rules, an employee may not make pre-tax, Roth, and/or post-tax contributions or receive Company contributions on pay over \$275,000 in 2018. This limit may be adjusted from time to time to reflect changes in the cost of living.
- **Catch-up contribution limit** - If you are age 50 or over, you can contribute up to an additional \$6,000 in pre-tax and/or Roth dollars after you have reached the IRS maximum of \$18,500 (or if you have reached any applicable Plan limits, if lower). If your combined contributions exceed this limit, you'll be notified.

Impact on Your W-2

Your pre-tax contributions to the 401(k) Plan reduce your taxable income and are not reported on your W-2 earnings statement. However, they are included when determining your Social Security taxes and other Ryder benefits.

Company Contributions

Any Company Contributions, Company Matching Contributions and Company Discretionary Contributions (collectively "Company contributions") are subject to the 401(k) Plan's eligibility provision of the first of the month on or after a one-year waiting period in which you have worked 1,000 hours and attainment of age 21. Company contributions, when applicable, are deposited into the same investment options you select for your own contributions. Company contributions are made to individuals based on their assigned business segment, generally defined as either Hourly and Salaried Employees, or Field Hourly, Driver and Warehouse Employees. Any Company Matching Contributions to either your pre-tax plan or Roth are made only into your pre-tax plan. The various employee categories are described in the following charts assuming you have met eligibility requirements:

401(k) SAVINGS PLAN**EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2016**

Employee Category	Company Contribution (no employee contribution required)	Company Matching Contribution (if you contribute on a pre-tax and/or Roth basis to the 401(k) Plan, Ryder will match your contribution)
All Employees Except as noted below	N/A	50% of your pre-tax and/or Roth contributions up to 6% of your eligible pay
Employees who became eligible to participate in the 401(k) Plan on November 1, 2017 in accordance with the Company's negotiation to withdraw from the Central States Pension Fund with respect to its Ft. Wayne, Lima, Massillon and Milwaukee contracts	3% of eligible pay*	50% of your pre-tax and/or Roth contributions up to 5% of your eligible pay

*The contribution will be funded in January of the following year. An employee must be in an Active status on December 31st of the year to be eligible for Company Contributions. Accordingly, those employees who terminate throughout the year, prior to December 31st, will not earn any Company Contributions in the year of separation.

EMPLOYEES HIRED BEFORE JANUARY 1, 2016

Employee Category (Notwithstanding, if such grandfathered employee terminates employment and is later rehired they would be eligible to receive Company contributions in the same manner as a newly hired employee after January 1, 2016)	Company Contribution (no employee contribution required)	Company Matching Contribution (if you contribute on a pre-tax and/or Roth basis to the 401(k) Plan, Ryder will match your contribution)
All Hourly and Salaried Employees Hired Before January 1, 2016 and were (A) hired prior to January 1, 2007 and did not meet the eligibility requirements to be grandfathered in the Ryder System, Inc. Retirement Plan; or (B) hired after January 1, 2007 but before January 1, 2016	3% of eligible pay**	50% of your pre-tax and/or Roth contributions up to 5% of your eligible pay
Hourly and Salaried Employees who were offered and made an irrevocable election in 2007 to continue to accrue benefits under the Ryder System, Inc. Retirement Plan	N/A	N/A
Field Hourly, Driver and Warehouse Employees (generally defined as hourly employees of Ryder's Supply Chain business, including drivers, warehouse employees and hourly support service employees, and including employees who work under the provisions of a collective bargaining agreement which agreement specifically includes benefits under the 401(k) Plan):	\$400** (not applicable to Field Hourly, Driver and Warehouse employees who, were employed with Total Logistic Control (TLC) and hired by Ryder on January 1, 2011 as part of the acquisition)	100% on contributions that do not exceed \$300; 50% on contributions that exceed \$300 but do not exceed \$1,100

401(k) SAVINGS PLAN**EMPLOYEES HIRED BEFORE JANUARY 1, 2016, continued**

Employee Category (Notwithstanding, if such grandfathered employee terminates employment and is later rehired they would be eligible to receive Company contributions in the same manner as a newly hired employee after January 1, 2016)	Company Contribution (no employee contribution required)	Company Matching Contribution (if you contribute on a pre-tax and/or Roth basis to the 401(k) Plan, Ryder will match your contribution)
Field Hourly, Driver and Warehouse employees who, were employed with Total Logistic Control (TLC) and hired by Ryder on January 1, 2011 as part of the acquisition	N/A	100% on contributions up to 4% of contributions plus 50% of next 2% of contributions
<p data-bbox="203 562 771 613"><u>Field Hourly, Driver and Warehouse employees who were:</u></p> <ul data-bbox="203 646 771 1621" style="list-style-type: none"> • employed by Scully Distribution Services and hired by Ryder on January 29, 2011 as part of the acquisition, • hired by Ryder Integrated Logistics of California, LLC after this acquisition but before Ryder Integrated Logistics of California, LLC merged into its parent, Ryder Integrated Logistics, Inc. on July 1, 2011, • hired by Ryder Integrated Logistics, Inc. after June 30, 2011 who work on one of the following customer accounts: (i) Best Foods, (ii) Big 5, (iii) Chase Brass, (iv) Domtar, (v) Ed Don, (vi) Excel, (vii) Franklin, (viii) Stockton Driver Pool (ix) Fresh-Easy, (x) Home Depot, (xi) LA Times, (xii) Fontana Driver Pool, (xiii) Staples, (xiv) Target, (xv) Tension Envelope, (xvi) Tharco, (xvii) C&S Wholesale, (xviii) Ralphs, (xix) Vallarta Company, (xx) Smurfit, (xxi) So Cal Pool, (xxii) No Cal Pool, (xxiii) Franklin, (xxiv) Tharco; or • hired into the Company's Dedicated Contract Carriage ("DCC") division on or after April 1, 2012, and who are employed to service a new customer account for a customer with a primary account location located in (i) Arizona, (ii) California, (iii) Washington, (iv) Oregon, (v) Utah, (vi) Idaho, or (vii) Nevada, or who were hired by the Company prior to April 1, 2012 and have been transferred on or after April 1, 2012 to service a customer account in any of the seven (7) the primary account locations noted above 	N/A	50% of your pre-tax and/or Roth contributions up to 6% of your eligible pay effective 1/1/16.

**The contribution will be funded in January of the following year. An employee must be in an Active status on December 31st of the year to be eligible for Company Contributions. Accordingly, those employees who terminate throughout the year, prior to December 31st, will not earn any Company Contributions in the year of separation.

401(k) SAVINGS PLAN**Vesting**

Vesting refers to the right to receive Company contributions credited to the 401(k) Plan. Once you are fully vested the Company contributions credited to your account are yours to keep, even if you leave Ryder. You are always 100% vested in your contributions as well as any rollover contributions. The vesting schedule is:

Years of Vesting Service	Vested Interest in Company Contributions
1 year	0%
2 years	25%
3 years	50%
4 years	75%
5 years or more	100%

You have one year of vesting service for each year of employment you have with Ryder.

You are 100% vested in the Company contributions credited to your account when you:

- Complete at least 5 years of vesting service;
- Reach age 65 ("Normal Retirement Age");
- Become permanently disabled while employed by Ryder; or
- Die while employed by Ryder. If you die while absent from employment due to a qualified military leave, you will be considered to have died while employed.

Field Hourly, Driver and Warehouse Employees are always 100% vested in Company Contributions. Field Hourly, Driver and Warehouse Employees hired before January 1, 2016 are fully vested in the first \$300 of Company Matching Contributions.

If you leave the Company before retirement, you will forfeit any unvested portion of the Company's contributions credited to your account. For example, if you leave the Company after 3 years of vesting service and your Company contributions and earnings are \$800, you will receive \$400 (50% of \$800). However, if you return to employment within 5 years, the forfeited amount will be restored and you will be able to become vested in that amount through your re-employment.

If you separate from service and are later re-employed, the following rules apply:

- If you left with at least a partial vested interest in Company contributions or, if you had no vested interest in Company contributions but had made pre-tax and/or Roth contributions to the 401(k) Plan, the service you earned before the separation will be included in determining the vested interest in Company contributions made after you return.
- If you left with no vested interest in Company contributions, and you had not made pre-tax and/or Roth contributions to the 401(k) Plan, the service you earned before the separation will be included in determining the vested interest in Company contributions made after you return, only if you return within five years of your original separation (or within a period of time equal to the service you earned before the separation, if longer).

Acquisitions

All employees of Scully Transportation Services who were hired by Ryder Truck Rental, Inc. as of January 29, 2011 as part of the acquisition are credited with their service with Scully Transportation Services for all plan purposes. Similarly, all employees of Scully Distribution Services who were hired by Ryder Integrated Logistics of California, LLC ("RIL California") as of January 29, 2011 as part of the acquisition as well as employees hired by RIL California after this acquisition but before RIL California

401(k) SAVINGS PLAN

merged into its parent, Ryder Integrated Logistics, Inc. on July 1, 2011, are credited with their service with Scully Distribution Services and with RIL California (as of June 30, 2011) for all plan purposes.

All Salaried and Field Hourly, Driver and Warehouse employees who were employed by Total Logistics Control and hired by Ryder on January 1, 2011 are fully vested in their accounts.

All employees of Dallas Service Center, Inc. who were hired by Ryder as part of its acquisition of the stock of Dallas Service Center, Inc. on September 29, 2017 are credited with their service with Dallas Service Center, Inc. for all plan purposes.

Plan Merger

The Ryder Integrated Logistics, Inc. 401(k) Profit Sharing Plan (the "RIL, Inc. Plan") was merged into the 401(k) Plan effective October 1, 2013. If you were a participant in the RIL, Inc. Plan, your accounts under the RIL, Inc. Plan were transferred to accounts under the Plan that are most similar to your RIL, Inc. Plan accounts, except as described below. All protected features and benefits of the RIL, Inc. Plan remain protected under the Plan.

The general Plan terms apply to you, except as noted below.

Any amounts in your Elective Account under the RIL, Inc. Plan were transferred to a new account established for you under the Plan, titled "Prior Scully Deferral Contributions Account." The rules under the Savings Plan that apply to your Tax-Deferred Contributions Account similarly apply to your Prior Scully Deferral Contributions Account, except that there is no limit on the number of in-service withdrawals at age 59 ½ that you may request in a Plan Year from your Prior Scully Deferral Contributions Account.

Any amounts in your Qualified Matching Account and Qualified Non-Elective Account under the RIL, Inc. Plan were transferred to the Tax-Deferred Contribution Account established for you under the Plan. These transferred amounts are not available for any in-service withdrawals on account of hardship.

Any amounts in your Roth Deferral Account under the RIL, Inc. Plan were transferred to a new Roth Deferral Account established for you under the Plan. Until June 1, 2018, amounts in your Roth Deferral Account are not available for any in-service withdrawals on account of hardship. However, this rule no longer applies on and after June 1, 2018.

Miscellaneous

Former Boral Industries, Inc. ("Boral") Employees: If you became employed by Ryder Integrated Logistics, Inc. ("RIL") on or before April 15, 2013 as part of the Transportation Agreement dated December 14, 2012 between RIL and Boral, then you became eligible to receive Company contributions under the 401(k) Plan as of the first day of the month that coincided with or next followed the date you became eligible to participate in the Plan (that is, the date you became eligible to make pre-tax contributions under the Plan). Accordingly, the one-year eligibility and age 21 requirements for Company contributions did not apply to you.

Rollovers

A rollover is a transfer of money from one eligible rollover plan to another. An "eligible rollover plan" is one that meets certain IRS requirements and is eligible for special tax advantages.

The 401(k) Plan both accepts, with the consent of the Retirement Committee, or its designee, rollovers from other eligible rollover plans and distributes amounts from the 401(k) Plan under the rollover rules.

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Generally, an eligible rollover plan includes another qualified plan, an individual retirement account, an individual retirement annuity, an annuity plan described in section 403(a) of the Internal Revenue Code of 1986, as amended (the "Code"), an eligible deferred compensation plan described in section 457(b) of the Code or an annuity plan described in section 403(b) of the Code. You will continue to defer taxes on the amount you roll over. Also, a rollover is not subject to early withdrawal penalties.

Rollover contributions must be deposited to the 401(k) Plan within 60 days of the check date. If you miss this deadline, you will have to pay income tax and possibly early withdrawal penalties on your distribution. Note that you may also have a rollover directly transferred from the eligible rollover plan into the 401(k) Plan.

Roth Rollovers

A Roth rollover is the same as a regular rollover, except that it is made to the 401(k) Plan from the designated Roth account of an eligible rollover plan. Also, if when you ultimately receive any Roth rollover you make to the 401(k) Plan you again wish to roll it over, you may only do so to a Roth IRA or to the designated Roth account under another plan that accepts Roth rollovers.

Plan Loans

The purpose of the 401(k) Plan is to build a retirement fund. However, you may obtain a loan from your account balance. You pay a rate of interest equal to the prevailing prime rate at the time of your loan. You repay that interest back to your own account. As you repay the loan, the money is reinvested according to your most recent investment choices.

Important Note: You do not earn interest, dividends or capital gains on money outstanding on a loan you have taken from the 401(k) Plan.

Loan terms include:

- Only two loans may be outstanding at one time, one general-purpose and one loan for the purchase or construction of your primary residence. You may not have two general-purpose loans. You may borrow up to half of your vested balance to a maximum of the following: \$50,000, minus the difference between your highest balance over the last 12 months of any outstanding loan against your account and the balance of any outstanding loan on the date you make this loan.
- The minimum amount you may borrow from your account is \$1,000.
- Payments are made through regular post-tax payroll deductions.
- Your loan amount must be repaid within five years (or up to 15 years if the loan is used to buy or construct your primary residence).
- You may repay the entire loan balance in a single lump sum. There is no penalty for prepayment.
- There is a 30 day waiting period before you can request a new loan after an existing loan has been fully paid off.
- Loans are not eligible for rollover.

Loan Fees

As of June 2018, a one-time \$50 processing fee will be charged to your account to cover costs for setting up and maintaining your loan. In addition, there is a \$25 yearly maintenance fee for all existing loans. It is deducted quarterly, in the amount of \$6.25 from your account. Fees are subject to change. Please review the Annual Fee Disclosure notice which summarizes all plan fees.

Loan Payments

Loan payments are usually made through payroll deductions on a post-tax basis. Deductions generally begin approximately 30 days after your loan is processed. If payroll deductions are not available to you,

401(k) SAVINGS PLAN

you may make monthly payments directly to the 401(k) Plan as instructed by the Ryder Retirement Service Center. You must pay repayments by certified check, cashier's check or money order. If you fail to make repayments when due, you will be deemed to have taken a distribution of your outstanding loan balance and will be taxed on such amount.

Loan payments are suspended during any unpaid FMLA or military leave.

Loan Balance After Termination

If you leave the Company before your loan is repaid, you may:

- Repay the outstanding loan balance in full;
- Take a distribution from the 401(k) Plan. Your distribution may be reduced by the amount of your outstanding loan. Your outstanding loan balance will be reported as taxable income; or
- Defer your distribution and continue monthly loan payments using payment coupons provided by the Ryder Retirement Service Center or elect monthly electronic fund transfers from your financial institution until the loan is repaid.

In-Service Withdrawals

You may withdraw money from your account if:

- You are at least age 59½;
- You have an extreme financial hardship as defined by the IRS;
- You have made post-tax contributions to the 401(k) Plan (non Roth post-tax contributions may be withdrawn at anytime); or
- You have rolled an account balance from an eligible rollover plan (rollover contributions may be withdrawn at any time).

Unless you elect otherwise, pre-tax contributions will be distributed to you before Roth contributions.

Withdrawals After Age 59½

Once you reach age 59½, you may withdraw all or part of your pre-tax and/or Roth account balance and the vested portion of your Company Contributions accounts – even if you continue to work for Ryder and make pre-tax and/or Roth contributions (and/or post-tax contributions) to the 401(k) Plan. Withdrawals after you reach age 59½ are not subject to an early withdrawal penalty. However, withdrawals of your pre-tax account balance are taxed as ordinary income, and earnings on your Roth contributions are taxed as ordinary income unless the withdrawal is a qualified distribution.

You may make up to two withdrawals in any calendar year. To request a withdrawal, call the Ryder Retirement Service Center to obtain a distribution package.

Hardship Withdrawals

You may request a withdrawal in the event of a financial hardship. Employee pre-tax and Roth contributions and the vested portion of Company Contributions, Matching Contributions and Discretionary Contributions are available for withdrawal. Hardship withdrawals are permitted based on IRS safe harbor guidelines, including:

- Purchase of your primary residence;
- Preventing eviction from, or foreclosure on, your primary residence;
- Tuition and related fees for post-secondary education for you, your spouse, your children, or your other dependents;
- Extraordinary tax deductible medical expenses incurred by you, your spouse or your dependents, which are not covered by your medical insurance plan;
- Burial or funeral expenses for your deceased parent, spouse, child or your other dependents; and
- Repair of damage to your primary residence that qualify for the casualty deduction under Internal Revenue Code section 165.

401(k) SAVINGS PLAN**Restrictions on Your Account**

If you receive a hardship withdrawal, you cannot make any contributions to the 401(k) Plan, the Ryder System, Inc. Employee Stock Purchase Plan (the "Stock Purchase Plan"), any deferred compensation plans and/or qualified or nonqualified stock options plans available to you for the 6-month period following the date of your hardship withdrawal.

Evidence of Hardship

If you are eligible for a loan under the 401(k) Plan, you must exhaust your loan options before any hardship withdrawal request can be granted. In addition, all in-service withdrawal options must be exhausted. A hardship withdrawal must include a statement of need and evidence of the hardship. For example, medical bills or housing contracts can be accepted as evidence.

Applying for a Hardship Withdrawal

Call the Ryder Retirement Service Center to request a hardship withdrawal package. Return the completed package to the Ryder Retirement Service Center as directed.

The Ryder Retirement Service Center will review the information you submit and make a determination of a hardship withdrawal based on IRS guidelines. You will receive notification of the 401(k) Plan's determination as soon as administratively possible after receipt of your request.

Tax Penalties on Hardship Withdrawals

The Ryder Retirement Service Center is required to withhold 20% of your distribution for federal withholding tax. The money you receive from a hardship withdrawal is taxable income to you. Unless you are at least age 59½ or are making the withdrawal to pay tax-deductible medical expenses, you are also required to pay a 10% tax penalty in addition to other federal, state and local income taxes that may be due.

IRS rules also require a six-month suspension of your ability to save through all employer plans that require elective deferrals or employee contributions. This means you cannot save in the 401(k) Plan, the Stock Purchase Plan or any deferred compensation plan or any qualified or non-qualified stock option plan available to you. You can however, continue to contribute to the Health Care and Dependent Care Flexible Spending Accounts.

Post-Tax Withdrawals

You can withdraw any post-tax contributions that you may have made to the 401(k) Plan and any associated earnings for any reason at any time, without penalty (post-tax withdrawals from the Roth Investment Account follows different rules). You do not have to pay income taxes on the post-tax contributions that you may have made. However, you will have to pay income tax on any earnings that are withdrawn.

Rollover Withdrawals

If you have previously rolled an account balance to the 401(k) Plan from an eligible rollover plan, you can withdraw the funds and any associated earnings for any reason at any time, without penalty. You will have to pay income taxes on the withdrawn amount (not including any post-tax contributions included in your account) at the time of distribution.

Roth Rollover Withdrawals

If you have previously rolled an account balance to the 401(k) Plan from the designated Roth account in an eligible rollover plan, you can withdraw the funds and any associated earnings for any reason at any time, without penalty. Withdrawals of your Roth Rollover contributions are not taxed, and earnings are not taxed as long as the withdrawal is a qualified distribution. A qualified distribution is one that occurs on or after the date you attain age 59-1/2 or the date you become disabled, and at least 5 years after the date you first made Roth contributions or a Roth rollover to the 401(k) Plan.

401(k) SAVINGS PLAN

Investment Options

The 401(k) Plan has several investment options to help you build your retirement savings. Descriptions of each of the funds are available in the 401(k) Plan enrollment materials, from the Ryder Retirement Service Center at 800-373-7300 or online at <http://netbenefits.fidelity.com>. Fund prospectuses are also available through the Ryder Retirement Service Center.

Accessing Account Information

Your account is valued at the close of each business day. Here are ways to access information about your account or to change your investment mix:

- You can go online to <http://netbenefits.fidelity.com> 24-hours a day, 7 days a week to view your account, make fund transfers, change payroll deductions, initiate a loan, and change your contribution election via this website.
- Call the Ryder Retirement Service Center at 800-373-7300 to receive assistance with your account.
- After you enroll, you will receive an annual statement showing account activity for the year. These statements include information about your account balance, contributions, investment changes, gains, and losses. The statements are mailed to your home address directly from the Ryder Retirement Service Center approximately 30 days after the close of the calendar year. Once you access your account activity online, the system will automatically set your online preference to suppress the mailed statements. At any time you can opt into receiving online statements instead of paper statements.

You Control Your Account

You should evaluate the investment options available under the 401(k) Plan in the same way you would evaluate any investment to determine whether you are comfortable with the investment risk and expected rate of return. The 401(k) Plan is intended to constitute a plan under Section 401 of the Employee Retirement Income Security Act of 1974 ("ERISA") and Title 29 of the Code of Federal Regulations Sections 2550.404c-1, and the fiduciaries of the 401(k) Plan will be relieved of liability for any losses which are the direct and necessary result of investment instructions given by you or your beneficiaries. You are urged to read the prospectus or other literature of each investment fund prior to making any investment decision.

To help protect the interests of all shareholders, the prospectus for Plan mutual funds states that the fund may temporarily or permanently terminate the exchange privilege of any investor who has a pattern of short-term or excessive trading or whose trading has been or may be disruptive to the fund. For these purposes, the Plan may consider an investor's trading history in the future or other mutual funds, and accounts under common ownership or control. In addition, each prospectus states that the fund may refuse any exchange purchase (into the fund) for any reason. An exchange is defined in the prospectus as "the redemption of all or a portion of the shares of one fund and the purchase of shares of another fund."

Confidentiality

Information regarding your account is subject to confidentiality requirements imposed on those who provide services to the 401(k) Plan. Fidelity is the record keeper and provides day-to-day administration for the 401(k) Plan.

401(k) SAVINGS PLAN**Administrative Expenses**

You are responsible for certain fees that are associated with the management of the 401(k) Plan, which are paid by the participants in the 401(k) Plan, including:

- Ryder Common Stock Fund trustee fee;
- Loan fees (if applicable to your account); and
- Other occasional administrative fees associated with satisfying fiduciary obligations of the 401(k) Plan, including 401(k) Plan communications.

These fees are deducted from your account and are reflected on your quarterly statement.

Distributions

The full value of your 401(k) Plan account is payable when:

- You retire at age 65;
- You become disabled (that is, you are approved for Social Security disability benefits);
- You die, and the distribution is payable to your surviving spouse or other beneficiary; or
- You terminate employment prior to age 65, death, or disability.

If, at the time you request a distribution, your vested account balance is:

- *\$1,000 or less* – you are required to receive a single lump sum payment. You may roll over the distribution to another eligible rollover plan.
- *Greater than \$1,000* – you may choose to receive payment from the 401(k) Plan immediately or wait and request payment at a later date. Your account will share in the investment gains or losses of the funds. You may change your investment mix at any time. However, 401(k) Plan payments must begin no later than April 1 following the calendar year that you reach age 70 ½ (or if later, the calendar year in which you retire from Ryder).

Non-Spouse Beneficiary Rollovers

If a benefit from the 401(k) Plan becomes payable to a beneficiary of yours who is not your spouse, the beneficiary may roll over the benefit (through a direct rollover) to an individual retirement account or individual retirement annuity.

Payment Options

Your distribution will be in the form of a lump-sum distribution of your total account balance. Distributions from the Ryder Common Stock Fund can be made in shares instead of cash if your equity account has a balance greater than \$500. Fractional shares of Ryder common stock will be paid in cash.

When you Reach Age 70½

Distributions from the 401(k) Plan must begin by April 1 following the calendar year in which you reach age 70½, or if later, the calendar year in which you retire from Ryder.

Rollover of Roth Amounts

If you wish to rollover a distribution, the amount of the distribution attributable to your Roth contributions and Roth Rollover contributions may only be rolled over to a Roth IRA or to the designated Roth account under another plan that accepts Roth rollovers.

Taxes

The IRS has established guidelines for taxes on distributions from the 401(k) Plan. You may want to consult a tax advisor before receiving a distribution.

401(k) SAVINGS PLAN

Types of Taxes

The following types of taxes can affect a distribution from the 401(k) Plan:

- Ordinary income tax;
- 10% penalty tax;
- 20% withholding tax; and
- 50% penalty tax.

Ordinary Income Tax

When you or your beneficiary receive a distribution from the 401(k) Plan, you will owe federal and, if applicable, state and local income taxes on the amount of your distribution unless you rollover your distribution to an eligible rollover plan. You will not owe federal income tax on a distribution of post-tax contributions or a distribution of Roth contributions that is a qualified distribution.

10% Penalty Tax

The IRS imposes this early withdrawal tax on certain distributions and withdrawals. A 10% penalty tax *will not* apply if:

- A distribution is made to your beneficiary or estate upon your death.
- A distribution is made because you are totally and permanently disabled.
- A distribution to your spouse or dependent is required under the terms of a qualified domestic relations order (QDRO) issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the 401(k) Plan to your spouse, child, or other dependent. If a QDRO is received by the administrator, all or portions of your benefits may be used to satisfy the obligation. It is the plan administrator's responsibility to determine the validity of a QDRO.
- The distribution is used for unreimbursed tax-deductible medical expenses paid during the taxable year that exceed 10% of your adjusted gross income.
- The distribution is made after you reach age 59½ or after you terminate employment after reaching age 55 or older.
-
- A distribution is made due to an IRS levy under Internal Revenue Code Section 6331.

You can avoid the 10% penalty tax by arranging a rollover (direct or otherwise) of the amount withdrawn to an eligible rollover plan.

20% Withholding Tax

The IRS requires the 401(k) Plan to withhold 20% of the taxable portion of a withdrawal. This means that if the withdrawal check is made out to you, 20% will be withheld for taxes.

You can avoid the 20% withholding requirements by arranging a direct rollover of the amount withdrawn to an eligible rollover plan. Note that if you opt for a 60-day non-direct rollover, the 20% withholding requirements will apply.

Keep in mind that the withholding rate (20%) doesn't necessarily determine the tax you will actually pay, which may vary depending on your personal circumstances.

50% Penalty Tax

Plan provisions state that payments from your 401(k) Plan must generally begin no later than April 1 of the year following the year in which you reach age 70½ or retire, if later. Subsequent distributions are required by December 31. So, for example, if your initial distribution is made on the April 1 following the year you reach age 70½, another distribution will have to be made by December 31 of that same calendar year.

401(k) SAVINGS PLAN

You are required to withdraw no less than the required minimum distribution ("RMD") from the 401(k) Plan, which is calculated according to certain IRS life expectancy tables. The Ryder Retirement Service Center will notify you of the amount of the RMD. You are responsible for ensuring that the distribution is made in a timely manner. If payment is not made by the required date or is less than the calculated RMD, a 50% penalty tax will be levied on the portion of your account that should have been paid to you.

Effect on Social Security

Saving with pre-tax dollars through the 401(k) Plan does not reduce your earnings for Social Security purposes. You pay Social Security (FICA) and Medicare taxes on your tax-deferred contributions to the 401(k) Plan, and these earnings are considered in your Social Security benefit.

Assignment of Benefits

A participant may not assign the benefit to which he is entitled, or any interest he may have in the assets of the 401(k) Plan (for example, to pay a debt). No lien may be created on any funds, securities or other property held under the 401(k) Plan, and a participant's benefit or interest in the assets of the 401(k) Plan cannot be reached by any creditor, except as may be permitted by law. However, a participant's interest may be subject to the terms of a Qualified Domestic Relations Order ("QDRO") relating to provisions for divorce, child support, alimony or property agreements involving a spouse, former spouse or dependent, as required by ERISA and the Internal Revenue Code. A QDRO may allow payment to an alternate payee to commence regardless of the age or status of the participant.

You can obtain, without charge, a copy of the 401(k) Plan's Qualified Domestic Relations Order procedures by contacting the Ryder Retirement Service Center.

No Insurance of Accounts

Because the plan is a defined contribution plan, your accounts are not insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. The PBGC does not insure benefits under defined contribution plans.

OTHER BENEFITS

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD

OTHER BENEFITS

Introduction

This section of your Summary Plan Description (SPD) book reviews benefit programs offered by the Company and are available to active, regular full-time employees. Many of the programs are provided at no cost and do not require enrollment. Specific information about enrollment for certain programs is provided in the information listed about each program. The additional benefit programs include:

- Employee Assistance Program;
- Health Advocate;
- Adoption Assistance;
- YouDecide.com;
- Power Financial Credit Union; and
- Direct Deposit and Pay Cards.

How The Programs Work

The Employee Assistance Program

To assist you in contributing your best at home and at work, the Company provides the Employee Assistance Program (EAP). The Employee Assistance Program makes available professional counseling for you and your family on a voluntary basis.

Eligibility

The Employee Assistance Program is available to all regular, full-time employees (eligible for medical coverage). Coverage becomes effective on the first of the month following 60 days (not to exceed 90 days) of continuous full-time employment. Dependents of eligible employees, as described in the Eligibility Section, are also eligible for coverage. You do not have to be enrolled in the Medical Plan to be eligible.

The following are *not eligible* to participate in the program:

- part-time, temporary and casual employees; and
- employees covered under a medical plan provided by a collective bargaining agreement.

What the Program Covers

The Employee Assistance Program (EAP) provides resources to help resolve personal concerns that may be affecting your health, well-being, family life or job performance. It provides confidential assistance to you and your family members 24/7.

In-person sessions are available with an EAP counselor in your area. The counselor will help you evaluate your concerns and suggest the next best steps. You may contact the EAP for any number of reasons, including:

- stress related to work, family and personal life;
- grief and bereavement counseling;
- marital, family and parent-child issues;
- anxiety or depression;
- coping with change and transition;
- financial and legal concerns; and
- problems with alcohol and/or drugs.

What Does the EAP Include?

- up to five counseling sessions per eligible person per year at no cost to you;
- 24/7 phone access to live counselors, 365 days a year for assessment and referral;
- legal services: one-consultation per legal matter;
- financial services: one consultation per financial matter; and
- short-term counseling and/or referrals to community resources.

OTHER BENEFITS

How to Access the EAP

Call 800-323-0751 to access services and plan to spend up to 15 minutes with an EAP counselor for an initial phone interview. You may also contact the program online at www.feibh.com and enter the user name: rsi

Health Advocate

Health Advocate is a Company-provided benefit for employees enrolled in a Ryder Medical Plan. Health Advocate helps you and your entire family, navigate the health care system and maximize your benefits. You, your spouse or domestic partner, dependent children, parents, and parents-in-law are covered at no cost. Health Advocate will assist with clinical and administrative issues involving medical, hospital, vision, dental, pharmacy and other health care needs. This program is not a substitute for health insurance. Rather, it complements basic health coverage by providing a range of services as outlined below.

How it Works

If you need help with a health care or insurance issue, just call Health Advocate's toll-free number at 866-695-8622. The first time you call, you will speak with a Personal Health Advocate (PHA). You will be asked to complete a short authorization form.

Services Provided

Typically you will speak with the same PHA every time you call. Your PHA will help you to:

- understand your benefit plan provisions and features;
- untangle insurance claims;
- find qualified doctors and hospitals;
- locate and research treatments for a medical condition, including "best-in-class" medical facilities;
- secure appointments with hard-to-reach specialists;
- assist with eldercare issues; and
- prepare for health care appointments.

You or a covered family member may call as often as needed. Health Advocate can be accessed 24/7. Normal business hours are Monday - Friday between 8am-9pm Eastern Time. A message service is also available after hours and during weekends.

Adoption Assistance

If you are a full-time employee enrolled in a Ryder Medical Plan at the time of initiating and at the time the adoption is finalized, you are eligible to receive up to \$2,000 for qualified expenses related to the legally recognized adoption of a child. The benefit is limited to two adoptions per family, per lifetime. If both adoptive parents are employed by Ryder, the maximum number of adoptions allowed is two and the maximum benefit allowed is \$4,000. To receive benefits, the child you adopt must be under the age of 18 at the time of the adoption and cannot be a relative or a stepchild of the adopting parents.

Covered Expenses Include

- state licensed adoption agency fees, including placement and parental counseling fees;
- legal costs, including attorney's fees and court costs;
- state required pre- and post-placement home study program, if applicable;
- medical expenses of the natural mother associated with child birth (i.e. obstetrician fees, anesthesiologist);
- temporary foster care before placement of the child in your home; and
- reasonable and customary transportation and lodging expenses to obtain physical custody of the adopted child.

Expenses not covered by the Plan include

- temporary living expenses incurred by the natural mother;
- room and board expenses of the natural mother associated with the delivery of the child; and
- expenses incurred after the final date of adoption.

OTHER BENEFITS**How to File for Reimbursement**

Adoption Assistance Forms are available by contacting the Benefits Department at 305-500-5954.

Your request for reimbursement must include:

- the completed *Adoption Assistance Reimbursement Request Form*;
- itemized bills or receipts which indicate the type of expense, date the expense was incurred and the amount of the expense (these expenses can only be submitted for reimbursement *AFTER* the effective date of the adoption); and
- a copy of the Adoption Certificate.

Reimbursement requests can be mailed or faxed to: **Ryder Benefits Department, 11690 NW 105 Street, Miami, FL 33178-1103 or faxed to 305-500-4342.** Forms that are incomplete or missing proper documentation will not be processed until the missing information is provided.

Claim Deadline

Requests for reimbursement under Adoption Assistance **MUST** be submitted within 90 days of the effective date of the adoption or the request will not be considered for reimbursement.

Taxes

Ryder does not withhold income taxes on the reimbursement amount paid; you will be responsible for adjusting your Form 1040 to include in your gross income statement the taxable portion of the reimbursement. Please consult a tax advisor to find out if this benefit is taxable to you.

Important Note: Ryder is not responsible for and does not provide any of the adoption assistance or legal services described in the Adoption Assistance summary or Hyatt Legal Plan section of this book. The professional advice that you receive from the attorneys or other providers under these programs is not attributable to Ryder and you should not request advice or consultation on these matters from any Ryder employee. In the event that you are dissatisfied with the advice provided to you under these programs, please contact the provider of these services directly. Ryder shall not be liable for any malpractice, or other liability in connection with the provision of these services.

Employee Discount Program

In addition to the customer discounts offered to employees, Ryder continues to add new programs as they become available. Log onto www.Ryder.com and go to Employee Discounts and Incentives. You will find discounts on Automotive, Consumer Goods, Mobility Services, Travel and Hotels.

Power Financial Credit Union

The Power Financial Credit Union is a financial institution that is dedicated to providing a full range of services to Ryder employees, including savings accounts and checking accounts; investments; ATM/Debit cards; direct deposit; financial counseling; mortgages, home equity loans, auto loans, boat and motorcycle loans; business and personal loans; and credit cards.

For more information visit the website at www.powerfi.org or call 1-800-548-5465.

Direct Deposit and Pay Cards

Direct deposit is a safe and convenient way to have your payroll check electronically deposited into the financial institution of your choice. Ryder makes direct deposit available to all employees. Ryder also provides Pay Cards which gives you access to your pay through a nationwide network of ATMs. To arrange for direct deposit of your paychecks or for further information about Pay Cards contact payroll at 305-500-3058, your location supervisor or your Human Resources representative.

RETIREMENT PLAN

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

RETIREMENT PLAN**Introduction**

The Ryder System, Inc. Retirement Plan is a type of pension plan from which eligible participants receive a specified monthly benefit at retirement that is based on a formula generally taking into consideration annual earnings and years of service. The Retirement Plan is funded by the Company, and is intended to supplement retirement income that may be available from the Ryder System, Inc. 401(k) Savings Plan (the "401(k) Plan"), other personal savings, and Social Security.

For a list of participating employers in the Retirement Plan, please contact the Plan Administrator at 305-500-5807.

Eligibility**Employees**

Participation in the Retirement Plan was frozen as of January 1, 2007 for new hires except for certain employees covered by a collective bargaining agreement that continued to provide for their participation in the Plan.

As a result, in general, if you were hired or re-hired on or after January 1, 2007, you are not eligible for the Retirement Plan. Instead, you are eligible for enrollment in the Ryder System, Inc. 401(k) Savings Plan.

Benefit accrual in the Retirement Plan for those participants who were hired prior to January 1, 2007 was generally frozen as of December 31, 2007 except for the following groups of employees:

- certain employees grandfathered into the Plan because they met specific tenure and age requirements and elected to remain in the Plan; and
- certain union employees whose terms and conditions of employment are covered by a collective bargaining agreement that continued to provide for their participation in the Plan ("grandfathered participants").

If you are not in the grandfathered group and your benefits were frozen on December 31, 2007, the benefits you already earned remain in the Retirement Plan and cannot be taken from you.

Union Employees

If you work under the provisions of a collective bargaining agreement, you are eligible to participate in the Retirement Plan *only* if the collective bargaining agreement provides for participation in the plan and you do not participate in a separate plan providing retirement benefits, negotiated by Ryder, or you met the requirements to continue to earn benefits under the Retirement Plan as of January 1, 2007.

Re-Employment

Any former employee who is rehired on or after January 1, 2007 shall not be eligible to resume participation in the Plan unless covered by the terms of a collective bargaining agreement providing for participation in the Plan. If, at the time of separation you did not have a vested interest, but returned to work, within five years, then the service earned prior to the separation will be reinstated for purposes of meeting the Plan's service vesting requirements.

Transfers

Employees who have been grandfathered into the Plan will retain their status in the Retirement Plan even if they transfer elsewhere in the Company, provided the new organizational assignment also participates in the Ryder Retirement Plan. However, benefits will be frozen on the effective date of transfer if the new organizational assignment is not eligible for participation in the plan or you transfer to a union group which participates in a separate plan providing retirement benefits.

RETIREMENT PLAN

Costs

Ryder pays the full cost of the Retirement Plan. You are not required nor permitted to make contributions to the Retirement Plan. Contributions to a special trust fund are made in accordance with yearly actuarial determinations.

How Your Retirement Benefits Are Calculated

The amount of your annual retirement benefit is based on your total annual earnings and years of service with the Company.

- **Total annual earnings** consist of your total pay received in a calendar year, including base pay, overtime pay, vacation pay, cost of living allowances, bonuses, pre-tax contributions to any Ryder plan involving IRS qualified salary reduction (like the 401(k) Plan), and commissions, up to the IRS limits.
- **A year of service** is a calendar year of participation in the plan in which you worked at least 1,000 hours.
- **Continuous service** is an uninterrupted period of time that you work for the company. Continuous service is used to determine if you qualify for early or disability retirement. Continuous service begins with your hire date and includes the time you are on an approved leave of absence (such as FMLA or military leave) or have a total and permanent disability.

You earn a portion of your benefit for each year of service that you are a participant in the Retirement Plan. Beginning January 1, 1989, the following formula is applied to your total annual earnings to determine the portion of benefits earned annually:

$1.45\% \text{ of total annual earnings of up to } \$15,600$ $+ 1.85\% \text{ of total annual earnings over } \$15,600$ $= \text{Benefit amount for each year of service}$
--

Example:

Jan's hire date is November 1, 2001. She is eligible to enter the Retirement Plan on January 1, 2003, and earns \$30,000 for that year of service. So in 2003, Jan will earn the following retirement benefit:

$$1.45\% \times \$15,600 = \$226.20$$

$$+ 1.85\% \times \$14,400 = \$266.40$$

$$\text{Total 2003 benefit accrued} = \$492.60$$

For the purpose of this example, assume that Jan's pay doesn't increase. Here's how her benefit would grow during her career with Ryder:

Year	Total Annual Benefit
1	\$ 492.60
10	\$ 4,926.00
20	\$ 9,852.00
30	\$14,778.00

When Jan retires at age 65 after 30 years of participation in the Retirement Plan, her annual benefit from the plan is \$14,778. This annual amount is divided by 12 and paid in monthly installments of \$1,231.50 as an individual life annuity.

RETIREMENT PLAN**Minimum Annual Benefit**

There is a minimum annual benefit for any Participant who meets the following requirements as of January 1, 1996:

- The Participant is an employee of a participating or affiliated employer as of January 1, 1996, or is earning accruals while disabled in accordance with Plan provisions as of such date.
- The Participant is accruing benefits in accordance with the provisions of the Plan as of January 1, 1996, or is a transferred member as of January 1, 1996.
- The Participant had not transferred out of the Plan to an ineligible status as of January 1, 1996.

The minimum annual benefit payable at age 65 from the plan is \$1,800, paid in 12 monthly installments of \$150 as an individual life annuity.

Vesting

Vesting refers to your right of ownership to receive a benefit from the plan.

- If you leave Ryder System, Inc. or any of its subsidiaries or affiliates before you've earned a vested interest, you have no right to a benefit from the Retirement Plan.
- You will earn a vested interest in the plan when you:
 - Complete five years of service with Ryder System, Inc. or any of its subsidiaries or affiliates, or
 - Reach age 65 while actively employed, even if you have fewer than five years of service with Ryder System, Inc. or any of its subsidiaries or affiliates.
- Years of service you complete with Ryder System, Inc. or any of its subsidiaries or affiliates before you become a participant in the retirement plan generally count toward your vested interest.
- Service with a company that was acquired by Ryder System, Inc. or one of its subsidiaries may also count toward your service for vesting purposes.
- In general, you earn a year of service for each plan year in which you are credited with at least 1,000 hours of service.

You continue to earn vesting service while employed by the Company. You will be credited with an hour of service for any hour for which you are paid or entitled to be paid by the Company, either because you worked or because you didn't work but were entitled to be paid (e.g., vacation, holiday, illness, incapacity (including disability), layoff, jury duty, qualified military service or leave of absence). No more than 501 hours of service will be credited to you on account of any single continuous period during which you perform no duties for the Company except for military service or an approved leave of absence.

You will not receive credit for periods during which you receive payments made to comply with worker's compensation, unemployment compensation or disability insurance laws, or payments that reimburse you for medical expenses. Unlike years of service for benefit accrual purposes, you begin earning vesting service on your date of employment with the Company or any affiliate of the Company as defined by the IRS.

After completing five or more years of service, you are 100% vested, which means you have a nonforfeitable right to a benefit in the future. If you have less than five years of vesting service, you are 0% vested, which means you have not earned the right to receive a benefit in the future.

Break in Service: You will incur a break in service if you are not credited with at least 501 hours of service in any calendar year. You will not have a break in service if you are absent from employment due to a family medical leave or military leave. For a family medical leave, you will be credited with up to 501 hours of service in the calendar year in which your absence begins however if you were already credited with at least 501 hours of service in the year in which the family medical leave begins, the hours will be credited to the next year if needed to avoid a break in service in that year.

RETIREMENT PLAN

Break in Service

The years of service you earn before a break in service will be restored when you return to work if:

- You had a vested interest before you left the Company, or
- You did not have a vested interest, but you are reemployed by the Company before you have five consecutive one year breaks in service.

However, you will lose whatever benefit and years of service you had earned before a break in service if:

- You did not have a vested interest before your break in service, and
- The time you were away from the Company exceeds a break in service of five years.

FMLA and Military Leaves

Your service will continue without a break for vesting purposes, if you are away from work due to an approved leave of absence including:

- A Family and Medical Leave (FMLA), which is limited to 12 weeks, or
- A military leave protected under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A qualified military service leave will be treated as service for vesting and benefit accrual. While on USERRA protected leave, your benefit accrual will be determined based on the total annual earnings you would have received during your military leave, or, if that isn't certain, your total annual earnings in effect before the military leave will be used to calculate your benefit accrual.

Early Retirement Benefit

Early retirement benefits are available when you:

- Have a vested interest,
- Have 10 or more years of continuous service with the Company, and
- Leave the Company between the ages 55 and 65.

You can begin receiving a benefit from the plan the first of the month after you leave the Company, or payment can begin on the first of any month thereafter.

Retirement Before Age 62

If you retire before you reach age 62, your benefit from the plan will be reduced because you'll receive a benefit over a longer period of time. If you retire between the ages of 62 and 65 there is no reduction in your benefit. The chart below shows how the benefit is reduced for each year that payment begins before age 62.

Reductions – Early Retirement

If you retire early and begin receiving a benefit from the plan before age 62, you'll receive your benefit over a longer period of time. So, your monthly payment amount is reduced. The annual reduction is prorated for a period of less than 12 months.

If payments begin at age:	You'll receive this percentage of your age 65 retirement benefit:
61	91.66%
60	83.34%
59	79.16%
58	75.00%
57	70.84%
56	66.67%
55	62.50%

RETIREMENT PLAN

Example: You retire at age 55 with an annual retirement benefit of \$12,000. If payment begins at age 55, your annual benefit would be $\$12,000 \times 62.50\% = \$7,500$.

Normal Retirement Benefit

Normal retirement age is 65. Normal retirement benefits begin on the first of the month on or after your 65th birthday.

If you work beyond age 65, and are a member of the grandfathered group, you will continue to earn retirement benefits pursuant to the benefit formula. Your benefit from the plan will normally begin on the first of the month on or after your retirement date. You must begin receiving payment from the plan by April 1st of the year following the calendar year in which you reach age 70½, or retire from Ryder. If you are a 5% owner of Ryder or one of its subsidiaries or affiliates, you must begin receiving payments from the plan by April 1st of the year following the calendar year in which you reach age 70½.

Disability Retirement Benefit

Disability retirement benefits are available from the plan if you are 100% vested and you reach age 45 with 15 years of continuous service at the time you suffer a total and permanent disability while actively employed by Ryder. You must also have been approved to receive Social Security disability benefits. This means you may start payment of your benefits at this time even if you have not reached your early retirement date under the Plan.

Your disability retirement benefit will equal the benefit you earned up to the date of your disability. You can begin receiving disability retirement benefits from the plan the first of the month after the later of the date you have met the above eligibility requirements and your pay from Ryder has ceased, or five months after the date you stopped working due to disability. The benefit will be unreduced for early commencement.

If you are grandfathered in the pension plan, are 100% vested and have at least 10 years of continuous service and become disabled, or if you are grandfathered and meet the requirements above to start payment of your disability retirement benefit, but do not want to commence right away, you will continue to earn benefits under the plan. If so, you will earn benefits until whichever is earliest:

- the date you reach age 65, or, if later, 5 years after the date your disability began,
- the date you elect early retirement,
- the date you recover, or
- the date you die.

The benefits you earn in this way will be based on the greater of your annualized pay rate at the time you become disabled or your total annual earnings for the last complete year you worked. If you elect early retirement, your benefit will be reduced if payment begins before age 62.

Certain causes of disability may not qualify you for benefits from the plan. The plan administrator reserves the right to select a physician to examine you periodically to verify that your total and permanent disability continues to qualify you for disability retirement benefits.

Suspension of Benefit Payments

Effective January 1, 2009, if you are reemployed by the Company while receiving your pension benefits, your benefit will continue. If you are reemployed by one of the unions for which continued participation and benefit accrual has been bargained, any additional benefits that you earn will be added to the benefit that you are already receiving. If you are a grandfathered participant, you will not earn additional benefits if you are reemployed.

RETIREMENT PLAN

Termination Benefits

If you leave Ryder for a reason other than retirement, death or total and permanent disability, you are entitled to receive the amount of your vested interest in the plan. Your vested interest is payable at age 65. This table applies to you if you terminate employment prior to age 55, but after you have completed at least ten continuous years of service. You may commence payment of your benefit when you reach 55 or at any later date you choose. If you commence payment before age 65, your benefit will be reduced based on the following chart.

Benefits for each year that payments are made before age 65 are reduced as follows:

If payments begin at age:	You'll receive this percentage of your age 65 retirement benefit:
64	93.33%
63	86.67%
62	80.00%
61	73.33%
60	66.67%
59	63.33%
58	60.00%
57	56.67%
56	53.33%
55	50.00%

If at the time you leave Ryder, you already met the requirements for an early retirement (that is, you already reached age 55 and had 10 years of continuous service) but did not choose to receive payment, benefits, when they become payable to you, will be reduced according to the chart shown under "Reductions - Early Retirement", and not the "Termination Benefits" table above.

Receiving Retirement Plan Benefits

Preparing for Retirement

You should contact the Ryder Retirement Service Center approximately 3 months before your desired retirement date. They will send you a retirement package that includes:

- An estimate of your benefit available under a number of different payment forms,
- Details about all the information and forms you must submit to receive benefits from the plan, and
- A request for copies of certain documents including your birth certificate, the birth certificate of your spouse or other beneficiary, and your marriage certificate. (If a beneficiary is initiating a survivor benefit request, proof of death will also be requested.)

Requesting a Plan Benefit

To receive a benefit from the plan, you or your beneficiary must submit the signed required forms to the Ryder Retirement Service Center for payment. If you are married, you must obtain your spouse's written, notarized consent to elect a form of payment that does not provide a survivor annuity to your spouse on your death. Forms are included in the package you receive from the Ryder Retirement Service Center.

Death Benefits

If you are receiving benefits from the plan and die, death benefits payable are determined by the payment option you selected.

RETIREMENT PLAN**Payment Options**

The Ryder Retirement Plan provides several forms of payment. Each payment option distributes benefits from the plan differently. You can select the form that best suits your retirement income needs. Payment options for plan benefits include:

- Individual Life Annuity,
- Joint and Survivor Annuity,
- Life with 10-year Certain Benefit, or
- Level Payment.

Individual Life Annuity

This option provides the full benefit amount in equal monthly payments for as long as you live. Survivor benefits are not payable with this option. If you are single when payments are to begin, your benefit will be paid in this form unless you elect otherwise.

Joint and Survivor Annuity

If you are married, you must select this option with your spouse as your contingent annuitant unless you elect otherwise with spousal consent. You may choose another payment option if you are married and have written notarized consent from your spouse to elect a different payment option or to choose someone other than your spouse as your contingent annuitant. If you are not married you may choose a contingent annuitant for this option.

With this payment option, you receive a monthly payment during your lifetime. After your death, your beneficiary will receive a percentage of your reduced monthly benefit. The percentage your beneficiary receives is determined by the option you select – 50%, 66 2/3%, 75% or 100%. The percentage you elect will affect the monthly amount you receive during your lifetime. The greater the percentage you select for your beneficiary, the lower the monthly payment paid during your lifetime.

Life and 10-Year Certain Annuity

If you elect this option, you will receive a monthly benefit for your lifetime. Payments are guaranteed for 10 years (120 months). If you die within the 10-year period, your benefit will continue to be paid to your beneficiary until the full 10 years of payments are made.

Level Payment

This payment option is only available if you elect to start payments from the plan before Social Security benefits begin. You will receive a larger monthly payment beginning with the date you retire and ending with the leveling age you elected (either age 62 or 65). Once you start receiving Social Security benefits, payment from the plan will be reduced to offset the amount you are receiving from Social Security. The net effect is to provide a level income throughout your retirement years. However, if payments from the plan will not at least equal \$50 per month after you begin receiving Social Security benefits, this option will not be available to you. You are responsible to apply for Social Security benefits at attainment of age 62 or 65 to coordinate with this payment option. Payments from the retirement plan end when you die. No survivor benefits are payable with this option.

Required Plan Distributions**Vested Balance \$5,000 or Less**

If the present value of your vested interest in the plan is greater than \$1,000, but less than \$5,000 and the required forms are not submitted to the Ryder Retirement Service Center in the required time, the distribution will be paid automatically and will be rolled over into a Fidelity IRA, which will be established in the name of the participant at the time.

If the present value of your vested interest in the plan is less than or equal to \$1,000 and the required forms are not submitted to the Ryder Retirement Service Center in the required time, the distribution will

RETIREMENT PLAN

be paid automatically and will be subject to the mandatory 20% federal tax withholding rate and any applicable state tax withholding.

If your distribution qualifies as an eligible rollover distribution, you may elect to have all or a portion of your benefit transferred directly into an eligible retirement plan, or an IRA. By doing so, you may delay taxes on your distribution.

At Age 70½

Distributions from the plan must begin by April 1st of the year following the calendar year in which you reach age 70½, or calendar year in which you retire from Ryder.

Surviving Spouse Benefits

Death Before You Begin Payment

Your spouse will be eligible for a plan benefit if you die after you are vested but before you begin receiving payments from the plan (whether you already left employment or not), and your benefit at retirement is valued at over \$5,000. Your spouse will receive a lifetime income benefit based on the benefit you earned up to the time of your death.

If your total benefit is valued at \$5,000 or less, your spouse will receive the full amount in a single lump sum payment.

If You Die Before You Leave Ryder

The amount of benefit your spouse receives is equal to the survivor's portion of the 50% joint and survivor annuity benefit. This will be calculated as if you had left Ryder on the day of your death, survived to age 65, and then retired.

If you have at least 10 years of continuous service when you die, your spouse may elect payment as early as:

- The month after you would have attained age 55, or
- If you are over age 55, the month following your death. The benefit will be subject to early retirement reductions.

Former Employees and Retirees

Your surviving spouse will receive a lifetime income based on the benefit you earned up to the time of your death if you are:

- Already retired, or
- Are no longer an employee, and
- Have a vested interest in the plan when you die, but have not yet received a benefit from the plan.

Amount of Spouse's Benefit

The amount of benefit payable to your spouse is equal to the survivor's portion of a 50% joint and survivor annuity, calculated as if you survived to age 65. Payment normally starts when you would have turned age 65. However, if you were age 65 or older at your death, payments can begin the month following your death.

If you have 10 years of continuous service at the time you leave the company, your spouse will receive the survivor's portion of the 50% joint and survivor annuity (subject to early retirement reductions). Benefits may begin on the month after you would have attained age 55 or the first of the month after your death, whichever is later.

If you are over age 55 and have 10 years of continuous service at the time you leave the company, your

RETIREMENT PLAN

spouse will receive the survivor's portion of a 50% joint and survivor annuity (subject to early retirement reductions). Benefit payments can begin as early as the first of the month after your death.

Important Plan Information**IRS Limits**

The IRS imposes a limit on the amount of annual earnings on which a benefit from the Retirement Plan can be based.

There is also an IRS limit on the amount of benefit you can receive from the plan. These limits change periodically as required by law. If you are affected by these limits, you will be notified. You may also be eligible for a benefit through the company's Benefit Restoration Plan.

Social Security

Both you and the Company contribute to the cost of your Social Security benefits over the course of your career. Social Security benefits normally begin at 65. Under the new Social Security guidelines, benefits may not begin until age 66 or later depending on your date of birth. In addition, your spouse may be eligible for Social Security benefits based on your earnings history.

Taxes

You are not required to pay current federal income taxes on your Plan benefits until you receive them. When you receive your Plan benefits in annuity form, you will owe current federal taxes. Federal income taxes will be withheld from your payments based on a form that you will complete prior to the commencement of your Plan benefit payments. You may also choose to have no federal income tax withheld from your payments. If you fail to return such form to the Plan, federal income tax will be withheld automatically using similar wage withholding elections previously made by you. Note that if you elect not to have withholding apply, or even if you do elect withholding, you may still owe additional taxes on the payments when you file your income tax return. You are responsible for payment of any taxes associated with the payments, and are advised to consult with your income tax advisor regarding the income tax consequences of the payments being made to you.

If you receive a lump sum payment from the Plan and roll this money over into an IRA or eligible retirement plan, you will not owe federal income taxes on the amount that you roll over at the time of the roll over. You may owe a 10% excise tax if your Plan benefits are paid to you in a lump sum before age 59 1/2, you do not make a rollover and you terminate employment before the beginning of the year in which you reach age 55.

Qualified Domestic Relations Order

Benefits payable under the Retirement Plan are for the sole purpose of providing benefits to Retirement Plan participants and their beneficiaries. Except as otherwise required by law or by the Retirement Plan document, no one has the right to anticipate, withdraw or assign the benefits payable to any other individual(s).

However, benefits will be paid according to a valid Qualified Domestic Relations Order (QDRO), if it is properly served. A QDRO is an order or judgment that meets certain specific requirements from a state court directing the plan administrator to pay all or a portion of a participant's Retirement Plan benefits to a former spouse or dependent.

The plan administrator has no discretion in these matters. However, every effort will be made to notify you as soon as it appears that an attempt is being made to assign your benefits through a court order.

Variations in Retirement Plan Provisions

There are some variations in coverage for certain employees of Ryder.

RETIREMENT PLAN

Non-exempt employees of the former named Ryder Dedicated Logistics, Inc. and Ryder Driver Leasing, Inc. who began participation in the RDL field variation of the Ryder System, Inc. Employee Savings Plan effective January 1, 1991, will not earn additional benefits in the Retirement Plan after December 31, 1990. Benefits accumulated before that date will be maintained in the Ryder System, Inc. Retirement Plan. Future service with the company will continue to count toward vesting and eligibility for early retirement.

Pension Benefit Guaranty Corporation

Your benefits under the Ryder System, Inc. Retirement Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay retirement benefits you would have received under their retirement plan, but some people may lose certain benefits.

What the PBGC Covers

The PBGC guarantee generally covers:

- Normal and early retirement benefits,
- Disability benefits if you become disabled before the plan terminates, and
- Certain benefits for your survivors.

What the PBGC Does Not Cover

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
- Some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the time the plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if a portion of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and how much the PBGC collects from employers.

Additional Information

For more information about the PBGC, talk with your plan administrator or contact:

- The PBGC's Technical Assistance Division, 1200 K Street, N.W. Suite 930, Washington, DC 20005-4026, or
- Call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-326-4000, or
- Connect online to the PBGC's Internet web site at www.pbgc.gov.

Benefit Accrual Restrictions

Benefits under the Plan may be restricted if the Plan becomes underfunded, meaning in general that the funding percentage of the Plan using methodology required by the IRS falls beneath 60%. If this occurs, benefit accrual under the Plan will cease entirely until the funding percentage improves. In addition the Level Payment Option may not be available if the funding level drops beneath 80%. If this occurs, you will be notified.

RETIREMENT PLAN

Receiving Information About Your Plan and Benefits:

You are entitled to:

- Receive a summary of the Retirement Plan's funded status. The Plan Administrator is required by law to furnish each participant with a copy of this annual funding notice.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. If you have a right to a pension, you will receive a statement at least once every three years if you are employed by the Company. You may also make a written request for a statement, but the Plan Administrator is not required to provide such a statement more than once a year. The Plan must provide the statement free of charge.

RYDERSHARES

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

Introduction

In this section, you will find an overview of the Stock Purchase Plan for Employees, also known as *RyderShares* (the "Plan"). It includes a description of the Plan and its features and instructions on how to participate in *RyderShares*.

Eligible employees of Ryder System, Inc., have a unique opportunity to buy shares of Ryder common stock at discounted prices through *RyderShares*. As a shareholder, you may share in the growth and success of Ryder both as an employee and as an owner.

The value of Ryder common stock purchased through *RyderShares* will vary with market conditions. Market values may go up or down. Any investment in common stock carries the possibility of loss as well as gain. Stock prices vary depending on how much owners are willing to sell shares for and how much buyers are willing to pay for shares. Prices are not fixed or regulated. It is important that you understand the tax consequences of an investment in Ryder common stock before committing your financial resources.

There is a detailed Plan Document that governs *RyderShares*. This is a summary of the information contained in the Plan Document and also constitutes a part of the prospectus covering the shares of Ryder common stock offered under the Plan that have been or will be registered under the Securities Act of 1933. If this summary inadvertently states anything that is inconsistent with the Plan Document, the language in the Plan Document governs. The Plan Document is available on-line at www.stockplanconnect.com or by writing to Ryder's Benefits Accounting Department, *RyderShares* Administration at 11690 NW 105th Street, Miami, Florida 33178 or by calling (305) 500-7732. To obtain additional information about the Plan and the administration of the Plan, you may contact Morgan Stanley at 888-301-0681.

Who Is an Eligible Employee

In general, any full-time or part-time active employee of Ryder or any of its U.S. or Canadian subsidiaries is eligible to participate. You are considered an active employee when you are performing your regular duties with Ryder or a participating subsidiary. You must also be an active employee for 90 days prior to the start of an offering period to be eligible to participate.

You are not eligible to participate if:

- You are customarily employed 20 hours or less per week;
- You own or would own 5 percent or more of the total combined voting power or value of all classes of stock of the Company, calculated under certain Internal Revenue Code rules, were you to participate in such offering period; or
- You are subject to the reporting requirements of Section 16 of the Securities Exchange Act of 1934, as amended.

When to Enroll

The enrollment period is the period of time during which an eligible employee may elect to participate in an offering. The enrollment period is the period commencing on the 15th day of the month prior to the month immediately preceding each offering period and ending the first day of each offering period. There are four enrollment periods each year. Contributions will begin on the first day of the next quarterly offering period, except if you enroll on the first day of an offering period, in which case contributions will begin on that day. The offering period is the period of time during which participating employees will make contributions and pay for their shares under the Plan. The offering period is the three-month period starting each January, April, July, and October.

RYDERSHARES

When you enroll between	Contributions begin
November 15 through January 1	January 1
February 15 through April 1	April 1
May 15 through July 1	July 1
August 15 through October 1	October 1

Once you enroll, contributions continue until you cancel or change your elections.

How to Enroll

Decide on the amount you want to contribute. There are three ways to enroll in *RyderShares*: 1) access the Morgan Stanley website at www.stockplanconnect.com and click on the icon "Enroll or adjust your contributions"; 2) use the *RyderShares* voice response system by calling (888) 301-0681 (if you are a first time caller you will be asked to establish a Personal Identification Number (PIN)); or 3) call (888) 301-0681 to speak with a customer service representative.

Administrative Services Provided By Morgan Stanley

Morgan Stanley Smith Barney, LLC ("Morgan Stanley") a member of the New York Stock Exchange, provides administrative services for *RyderShares* as the Plan broker. Through Morgan Stanley, you can enroll in *RyderShares*, maintain an individual account in your name and make any inquiries or changes to your account.

Shares are Purchased through Payroll Contributions

You may elect to contribute one of two ways:

- Elect between 1 percent and 15 percent of your base pay, or
- Elect a specific dollar amount. (There is a minimum election of \$5.00 per pay period.)

When you enroll in *RyderShares*, each paycheck will be reduced by the amount you elect to contribute. Your payroll contributions are taken on an after-tax basis. Payroll contributions will continue for subsequent quarters unless you contact Morgan Stanley directly to change the amount of your contribution or to cancel your participation in the program.

Regardless of the option you elect, you may not purchase more than 2,500 shares on any one purchase date or stock with an aggregate fair market value of more than \$25,000 in any calendar year.

Your contributions will be credited to a payroll deduction account established in your name and will be applied to the purchase of stock. Your total payroll contributions will be sent to Morgan Stanley at the end of each quarter.

You cannot make separate cash payments into your payroll contribution account. Payment for shares purchased through *RyderShares* can only be made with payroll contributions. Ryder will pay all of the administrative expenses for *RyderShares*.

How to Change Your Payroll Contributions

You may change the rate of your payroll contributions during the last calendar month of an offering period by calling Morgan Stanley at 888-301-0681 or accessing the website at www.stockplanconnect.com. Changes will take effect on the first day of the next offering period.

How to Stop Your Payroll Contributions and Withdraw from the Plan

Call Morgan Stanley at 888-301-0681 during the first two calendar months of an offering period to stop payroll contributions and withdraw from participating in *RyderShares*. After you discontinue payroll contributions, you can leave any previously purchased stock in your individual plan account without paying a maintenance charge. Ryder's Benefits Accounting department will process any cash in your

payroll contribution account, without interest, and payment will be made to you as soon as practicable following your withdrawal and you will not be entitled to any shares with respect to the offering period in effect at the time of withdrawal. If you call Morgan Stanley to withdraw your participation during the last calendar month of an offering period, your withdrawal will be effective for the next offering period.

If you stop payroll contributions during any offering period, you can start payroll contributions again by calling Morgan Stanley during any subsequent enrollment period, and contributions will be effective beginning with the offering period to which the enrollment period applies.

Important Note: During the last month of an offering period, cancellations will not be accepted. Any cancellation during the last month of an offering period will be effective for the next offering period.

Accessing Your Account

After enrolling in *RyderShares*, Morgan Stanley will send you information for accessing your stock account. The package will include information on activating your Trading PIN and certifying that you are not subject to Federal tax backup withholding. You must call Morgan Stanley at 888-301-0681 to activate and access your account.

Stock Purchases Are Made Each Quarter

At the end of each calendar quarter, Ryder will send Morgan Stanley the funds that have accumulated in your payroll contribution account. Morgan Stanley will establish an individual account in your name and purchase shares of Ryder common stock at the discounted price on your behalf.

All of Your Shares Are Purchased At a Discount

When you participate in *RyderShares*, you will receive a discount of 15% on the closing market price of Ryder common stock. Because you don't pay any brokerage commissions or other fees on purchases, 100% of your contributions will be used to purchase shares of Ryder common stock.

The price you pay for Ryder common stock will be 85% of the closing market price per share of Ryder common stock on the last trading day of the quarter.

The following example is for illustration purposes only and is not intended to show actual stock prices.

Closing Market price of Ryder Stock	Your purchase price is 85% of the price on the Last Day of the Quarter
Last Day of Quarter \$50	85% of \$50 or \$42.50

Stock prices are for illustration purposes only.

You Pay No Brokerage Commissions or Fees on Stock Purchases

Ryder will pay brokerage commissions and any fees related to the purchase of shares. Ryder will also reimburse Morgan Stanley for any operating costs related to opening and maintaining your individual *RyderShares* account. However, you will be charged brokerage fees and commissions when you sell your shares.

Shares Are Held In Your Account

At the end of each calendar quarter, shares are purchased and are allocated to an individual *RyderShares* account held in your name at Morgan Stanley. You immediately become the owner of the shares purchased.

RYDERSHARES**Restrictions on Transfer of Shares in Your Account**

During the offering period, you may not transfer or pledge your right to receive shares through *RyderShares* to anyone else. Once the shares purchased for you are in your account, you are subject to a 3-month holding period (12 month holding period for Vice Presidents and Senior Vice Presidents (MS14 – MS16). During the applicable holding period, you may not sell, transfer, or request a certificate. After the applicable holding period, you may sell or transfer your stock without restriction. You may instruct Morgan Stanley to issue you a stock certificate for any or all of the whole shares in your account. There will be a fee for this service. To request a certificate, call Morgan Stanley at 888-301-0681 for the appropriate form.

Example of 3-month Holding Period:

Enrollment	Offering Period	Purchase Date	Sell, Transfer, Certificate
December	January - March	Last Day of the Quarter	July *

* VP's and SVP's may not sell until the following March.

You Will Have Shareholder Privileges

When you purchase at least one share of common stock, you will receive:

- Notices of shareholder meetings
- Proxy statements
- Annual shareholder reports
- Other shareholder literature

If there are issues subject to a vote by shareholders, you will be able to vote the shares held in your *RyderShares* account. Your vote(s) will be cast by Morgan Stanley according to your instructions. In addition, shares held in your *RyderShares* account will be credited with dividends.

Dividends Are Credited To Your Account

Your individual *RyderShares* account at Morgan Stanley is credited with dividends. Any dividends paid on *Ryder System* common stock will be automatically credited to your account and reinvested in additional shares of *Ryder System* common stock at the current market value, unless you opt out of the dividend reinvestment program. These shares will be allocated directly to your account. *Ryder* will pay the brokerage fees for these purchases. Dividends on shares of stock that you have taken from your account in certificate form will not be reinvested but will be sent directly to your home in the form of a dividend check by the dividend-paying agent.

You Will Receive Regular Account Statements

Morgan Stanley will mail a statement of your account following each transaction that you make and after each quarterly allocation. This statement will give details on the transaction and show the previous and new share balances.

Tracking *Ryder System* Stock Prices

You can check *Ryder* stock performance in the newspaper or on the Internet. Look for "Ryder" under the NYSE in the financial section transactions listing in the business or financial section of most daily newspapers, or on the Internet, enter company symbol "R".

Your Account Is Protected By SIPC

Your account with Morgan Stanley is protected by the Securities Investors Protection Corporation (SIPC) for up to \$500,000. Morgan Stanley also provides additional protection for up to \$2 million. However, you are not protected against any losses from the rise or fall in the market value of your investment.

Sell Your Shares

RyderShares helps you build long-term financial security. However, if you want to sell part or all of your shares, you may do so by calling Morgan Stanley at 888-301-0681. You can speak with a customer service representative, use Morgan Stanley's Automated Stock Access Program (ASAP), a voice response system used with a touch-tone phone or access your account through the website at www.stockplanconnect.com. Morgan Stanley will sell your stock and send you a check for the net proceeds. The net proceeds of your sale will be reduced by the discounted brokerage commission and any applicable transfer taxes and fees.

Important Information about Tax Considerations

The following section about tax considerations should be read in its entirety. These are general guidelines intended only to alert employees to basic tax issues associated with participation in the Plan. It is the employee's responsibility to obtain professional advice, as he or she feels necessary prior to enrolling in the Plan. Neither the Company nor the Plan broker can give employees tax, legal or financial advice.

Tax Information for U.S. Employees under the Plan

Generally, you pay no taxes at the time you purchase shares. When you sell your shares or transfer them to a third party, you must report these activities on your tax return. When you report a transaction, you will need to know your cost basis in order to compute the proper amount of gain or loss. This will be listed on your original purchase statement, or you can contact Morgan Stanley for this information. You should keep statements of all purchases, sales and transfers of your stock with your tax records. You are encouraged to discuss the tax consequences of your participation in RyderShares with your own personal, legal, financial, and tax advisors.

Tax Information For Canadian Employees Under the Plan

Purchasing Shares

When an employee actually purchases the shares, the difference between the discounted price the employee pays for those shares under the Plan and the shares' market value on the date of purchase is *taxed as employment income*. This tax will be payable for the tax year during which the employee purchased the shares. Ryder will report the income to the Canada Revenue Agency and collect all applicable income and social taxes with respect to that income.

Dividends

Any dividends that you receive directly or that are credited to your account will be taxed as income from property. Ryder will not collect any tax from these dividends. However, US taxes may be withheld. It will be your obligation to report the gross amount of the dividends on your personal tax return. You will be able to claim a tax credit for the US taxes withheld from the dividends.

Disposing of Shares

Generally, the employee will recognize the gain or loss in the year in which the employee sells the stock. If the stock is held as capital property and the net sales price is higher than the employee's adjusted cost base in the stock, the gain is *taxed as a capital gain*. If the net sales price is lower than the employee's adjusted cost base in the stock, the loss is a capital loss. Only 50% of capital gains are taxable and 50% of capital losses are deductible against other taxable capital gains. The adjusted cost base of the shares will include the amount you paid for the shares and any benefit included in your employment income, generally adjusted for the cost of other Ryder stock that you have acquired and retained. You are encouraged to discuss the tax consequences of your participation in RyderShares with your own personal, legal, financial, and tax advisors.

RYDERSHARES**Additional Information Regarding The Plan****Ryder System, Inc. Determines the Rules Administering RyderShares**

RyderShares is administered by the Compensation Committee of the Ryder System, Inc. Board of Directors. Each member is a "non-employee director" as that term is used in Rule 16b-3 under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or any successor definition. The Committee has authority to interpret the Plan and decide all matters arising under RyderShares. RyderShares is intended to qualify under the provisions of Section 421 and Section 423 of the Internal Revenue Code.

RyderShares is not subject to the Employee Retirement Income Security Act of 1974, as amended, and is not a qualified plan under Section 401(a) of the Internal Revenue Code.

Ryder Has Registered Stock for RyderShares

Ryder has registered 4.5 Million shares of common stock, \$.50 par value, for issuance under RyderShares. No person has or may create a lien on any shares held in RyderShares either under the Plan or pursuant to any contracts in connection with the Plan.

Ryder Reserves the Right to Terminate RyderShares

The Plan continues until all of the shares approved for issuance have been sold pursuant to the Plan or the Plan is otherwise terminated. While Ryder expects to continue RyderShares indefinitely, because it is impossible to predict all future conditions, Ryder must reserve the right to terminate the Plan. If the Plan is terminated, you will be able to request a stock certificate, sell your shares or continue to have Morgan Stanley hold your shares for you in an individual account (this account will not be in RyderShares).

Documents Incorporated By Reference

The following documents filed with the Securities and Exchange Commission are incorporated herein by reference:

- a. The Company's most recent Annual Report on Form 10-K;
- b. All other reports filed by the Company or the Plan pursuant to Section 13(a) or 15(d) of the Exchange Act since the end of the fiscal year covered by the annual report referred to in (a) above;
- c. The description of the Company's common stock contained in its Registration Statement on Form S-3, No. 33-33600 filed with the Commission on February 27, 1990, as amended; and
- d. The description of the Company's common share purchase rights contained in its Registration Statement on Form 8-A filed with the Commission on April 3, 1996.

All reports and other documents subsequently filed by the Company or the Plan pursuant to Section 13(a), 13(c), 14 or 15(d) of the Exchange Act prior to the filing of a post-effective amendment which indicates that all securities offered hereby have been sold or which deregisters all securities then remaining unsold, shall be deemed to be incorporated by reference herein and to be a part hereof from the date of the filing of such reports and documents.

Participants may obtain without charge, upon written or oral request, a copy of any document incorporated herein, a copy of the Company's latest annual report to shareholders and any other reports, proxy statements and other communications distributed to shareholders generally by contacting the Executive Vice President, General Counsel and Secretary, Ryder System, Inc., 11690 NW 105th Street, Miami, Florida 33178.

Termination of Employment or Severance

Upon termination of employment for any reason, participation in RyderShares ends immediately. Any cash in your payroll contribution account will be paid to you (or your designated beneficiary, if applicable)

without interest as soon as practicable, and you will have no future rights to participate in the Plan. You may:

- Sell your shares in your individual Plan account.
- Request a stock certificate for all whole shares be mailed to you for a fee. The fractional interest will be sold and a check will be mailed to you.
- Keep your shares at Morgan Stanley. You will be responsible for any brokerage commissions or fees incurred as a result of any purchases or sales in this account.

Death

In the event of a death, the account becomes the property of your estate and may be settled only after all required legal notice and documentation

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Ng Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Definitions

A number of words and phrases have a specific meaning when used to describe your Ryder Benefits Package. The following definitions are superseded to the extent a specific definition is provided in a particular section of this benefit summary.

Accelerated Death Benefit: advance payment of basic and/or additional life insurance if you become terminally ill.

Accident: for the purposes of the seat belt/safety net benefit, means the unintentional collision of a motor vehicle (four-wheel, private passenger car, pickup truck, station wagon, van, or jeep-type vehicle) not being used for the transportation of passengers for hire.

Actively at work: performing the duties of your job at your normal place of work. You will be considered actively at work while on vacation, on an unrelated approved Workers' Compensation leave or during Company-sponsored holidays if you were actively at work on the regular workday immediately before the vacation, Workers' Compensation leave or holiday.

Active full-time employee: an employee classified as full-time who works 30 hours per week or more for Ryder System, Inc. or one of its subsidiaries or affiliates on a regular basis in the usual course of Company business.

Annual enrollment: the designated period of time when an employee may elect to change or continue certain benefit plan participation for the next Calendar Year.

Any occupation: for the LTD plan, any occupation that you are or become reasonably suited by training, education, experience, age, physical or mental capacity.

Assets: the property and resources (such as cash and investments) of a person or company. A mutual fund's assets are whatever securities (stocks, bonds, treasury bills, etc.) that it owns, plus any cash.

Beneficiary: the person or persons designated to receive 401(k) Savings Plan payments, AD&D death benefits or Life Insurance benefits payments if you die.

Benefit elimination period: the period of time you must be continuously disabled before STD or LTD benefits begin. For Non-salaried employees, the benefit elimination period for the STD plan is one week (7 continuous days) and the benefit elimination period for LTD is 26 weeks or the first 180 consecutive days of any period of disability. For Salaried employees, the elimination period for the STD plan is one week (7 continuous days) and the benefit elimination period for the LTD plan is 5 months or the first 150 consecutive days of any period of disability.

Birthday rule: if your children are covered under two parent's plans, the plan of the parent whose birthday falls earlier in the calendar year pays benefits first. If both parents have the same birthday, the plan that has covered the family for a longer period of time pays benefits first.

Bonds: loans or debt issued by corporations, governments or municipalities to raise money. A bond is like an IOU. It shows the amount loaned (principal), the rate of interest to be paid on the loan, and the

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date that the principal will be paid back (maturity date). Bonds pay periodic payments that create a fixed source of income. Mutual funds that invest primarily in bonds are called income funds.

Certificate of creditable coverage: a document that provides proof of prior health coverage by a previous employer or insurer.

Child(ren): your children up to age 26, including, generally, natural children, step-children, legally adopted children, children placed in your home for whom adoption proceedings have begun, and children for whom you are the legal guardian. Each benefit plan may provide a slightly different definition, thus, notwithstanding the preceding, "Child(ren)" for any benefit plan shall be as defined under the portion of the SPD describing that plan.

Coinsurance: the percentage portion of covered charges paid by the plan and the percentage portion of covered charges paid by the plan participant.

Common stocks: shares, usually represented by stock certificates. If you own stock, you own a part of the Company. Your ownership gives you the right to share in dividends and to vote on corporate matters that affect shareholders.

Company: Ryder System, Inc. and any of its subsidiaries or affiliates that provide benefits. Also referred to as Ryder.

Company Contributions and Company Matching Contributions: contributions to a Participant's 401(k) Savings Plan account made by Ryder.

Continuing benefit period: the period of disability that extends beyond the initial benefit period.

Continued claim: a period of short-term disability separated from another period of disability by a return of employment for less than or equal to 30 consecutive days, regardless of diagnosis.

Continuation coverage: when health care coverage ends for you and/or your dependents, you may be able to buy continuing coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). The number of months you can buy continuation of coverage depends on the reason coverage ended.

Copay: the amount that the participant must pay directly to a medical, dental, pharmacy or vision network provider for specific covered charges.

Covered charge(s): the usual and prevailing charge for a medical or dental service or supply that is:

- medically necessary for the treatment of illness or injury; and
- provided by a qualified, licensed and accredited hospital, health care facility, physician, or other health care professional operating within the scope of a professional license.

Deductible: the amount of covered charges you must pay each year before the Medical, Dental, or Prescription Plan will pay benefits.

Other Income: for the purposes of the LTD plan, any amount you receive or are eligible to receive because of your disability under any Workers' Compensation law or similar law, including amounts for permanent, temporary or vocational partial or total disability. This also includes any Social Security Disability or retirement benefits you, your spouse or your children under age 18 receive or are eligible to receive.

Dental specialist: a licensed dentist who has signed an agreement with a dental provider organization under which he/she agrees to provide specialized dental care service with an approved referral. Dental specialists include: Endodontists, Oral surgeons, Orthodontists, Pedodontists, and Periodontists.

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Dentist: any doctor of dental surgery (D.D.S. or D.M.D.), oral surgeon, or orthodontist licensed to render dental services within the scope of their practice. This includes any other dental doctors furnishing any dental services, which such doctor is licensed to perform.

Dependent(s): each benefit plan provides a slightly different definition, thus “Dependent(s)” for any given benefit plan shall be as defined under the portion of the SPD describing that plan.

Disability/disabled: for the purposes of the STD program, you are considered to be disabled if, as a result of a non-occupational illness or injury, you are unable to perform the material duties of your occupation.

Disability claims manager/administrator: the agent assigned by the plan administrator to perform all duties related to or concerning the payment of LTD or STD benefits or the delivery of services.

Domestic partner: a person of the same or opposite sex, if he or she has met all of the following criteria for at least 12 months before the coverage effective date:

- the individual and you are each other’s sole domestic partner and intend to remain so indefinitely;
- the individual and you are not married to or legally separated from each other or anyone else;
- the individual and you are not related by blood or adoption to a degree of closeness that would prohibit legal marriage in the state in which he or she resides;
- the individual is at least eighteen (18) years of age and mentally competent to consent to a contract;
- the individual and you are living together in the same residence and intend to do so indefinitely; and
- the individual and you are engaged in a committed relationship of mutual caring and support and are jointly responsible for each other’s common welfare and living expenses.

Earnings: each benefit plan provides a slightly different definition, thus “Earnings” for any given benefit plan shall be as defined under the portion of the SPD describing that plan. Examples:

Base pay: for purposes of the STD plan, this is the amount of regular salary or wages paid by your employer just prior to the date of disability. Your base pay will not be reduced by deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. Commissions, bonuses, overtime, incentive pay or any other extra compensation are not included in base pay.

Weekly base pay: for the purposes of the STD plan, for field hourly, driver and warehouse employees, is the average of the last 3 months (13 weeks) of earnings starting with the most recent completed full month of work prior to the date of your disability date. Weekly base pay includes overtime, bonuses, commissions, stops, starts, trips, mileage and other applicable wages.

Weekly base pay: for the purposes of the STD plan, for hourly employees, this is the number of hours you are normally scheduled to work each week, up to a maximum of 40 hours, multiplied by your base hourly rate of pay. Usually your annual base pay divided by 52 weeks. Weekly base pay excludes commissions, any overtime pay, bonuses, other fringe benefits or extra income.

Monthly base pay: for purposes of the STD plan, for salaried employees, this is your monthly salary, not including overtime, commissions, or compensation other than base pay.

Pre-disability earnings: for the purposes of the LTD plan, is based on your pre-disability earnings as of your last day worked, rounded to the next higher thousand. Pre-disability earnings is defined as the greater of: 1) the average of the two years of total earnings as of August 31 of the prior year, or 2)

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your base pay as of August 31 of the prior year, whichever is greater. August 31st of any given year determines the level of benefits in place as well as the premiums you will pay in the next Plan Year.

Indexed pre-disability earnings: means your monthly earnings in effect just prior to the date disability or partial disability began adjusted on the first anniversary of benefit payments and each anniversary thereafter. Your monthly earnings are increased annually by 7%, or the current annual percentage increase in the Consumer Price index, whichever is less.

Total Annual Earnings: the portion of earnings subject to withholding for purposes of Federal Income Taxes paid to the employee by the Company during the plan year, including: regular pay, overtime pay, vacation pay, cost-of-living allowances, bonuses, commissions, before tax contributions by an employee to a 401(k) plan or other plan involving IRS qualified salary reductions (such as section 125 cafeteria plan). All forms of imputed income, dividends paid on Restricted Stock rights and disqualifying dispositions of stock options under the Ryder System, Inc. stock plans, all types of company prerequisites and beginning with the 2002 plan cycle, cash awards and payments made under the Ryder System, Inc. Long Term Incentive Plan, are excluded.

Life Insurance: the amount of pay which your life insurance coverage is based on. For the purposes of the program, earnings are the greater of your total earnings or base pay, determined at your date of hire and updated once per year at annual enrollment. Total earnings are based upon the 12 months prior to September 1 of the previous plan year and include base pay, commissions, bonuses, overtime pay, trips, miles and stops, vacation, holiday, and sick pay, but not disability pay. August 31st of any given year determines the level of benefits in place as well as the premiums you will pay in the next Plan Year.

Emergency: a sudden, serious, and unexpected illness, injury, or condition that requires immediate medical attention due to severe pain, or to prevent the loss of life, permanent disfigurement or impairment of a bodily function or organ, or to prevent the loss of a tooth.

Equities: another term for stocks. When you own a part of something, you have “equity” in it. Investments in stocks are called “equities” and mutual funds that invest in stocks are often called “equity funds.”

Essential function: a function that is substantial, not incidental, is fundamental or inherent to the job, and cannot be easily omitted or changed.

Evidence of Insurability: also known as proof of good health or the requirement to complete a medical questionnaire as required by the life and disability claims administrator when increases in coverage are requested at annual enrollment.

Flexible Health Care Spending Account: A way to set aside money from your paycheck to pay for certain eligible health care expenses such as medical co-pays and deductibles, dental work, prescriptions, prescription glasses, contacts, etc. There is a maximum you can set aside for the year and if you don't use it, you lose it.

Flexible Dependent Care Spending Account: A way to set aside money from your paycheck to pay for eligible dependent care expenses. This account is used to pay for eligible, work-related expenses that are necessary for you and your spouse or domestic partner to work or attend school. The expenses must be for qualified individuals including your dependent child under the age of 13 who lives with you for more than half the year, or your spouse or other tax dependent who is physically or mentally incapable of self-care and lives with you more than half the year. Eligible expenses include, certified day care or day camp, before and after-school programs, baby-sitting services by qualified individuals and elder care service. There is a maximum you can set aside for the year and if you don't use it, you lose it.

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Health Savings Account (HSA): A tax-advantaged medical savings account available to those enrolled in the HSA Medical Plan. The funds contributed to an HSA account are not subject to federal income tax at the time of deposit. HSA funds roll over and accumulate year to year if they are not spent. HSAs accounts are owned by the individual and can be used to cover expenses now or in the future.

Highly Compensated Employee: an employee whose previous year's total annual earnings are equal to or exceed the amount determined by the IRS. The IRS rules limit the amount that higher-paid employees can contribute to tax advantaged plans. As a result, the total amount you may contribute to the Dependent Day Care Flexible Spending Account and/or 401(k) Savings Plan may be limited to a lower amount allowable by law.

Hours of service: each hour you are paid or are entitled to receive pay (such as vacation, holiday, illness, disability leave, layoff, jury duty, FMLA, military duty or military leave) for performing the duties of your job.

Ineligible status: for the purpose of eligibility, includes but is not limited to not yet meeting the eligibility waiting period, part-time status, transferring to a collective bargaining unit with no Ryder benefits and any leave of absence with no benefits.

Injury: bodily damage other than Sickness, including all related conditions and recurrent symptoms.

In-network provider: a health care provider who has contracted with a provider network to provide treatment or services under the plan and to accept negotiated rates. Also, a health care provider authorized by the benefits administrator. An in-network provider is also referred to as a "participating provider."

Investment mix: the combination of investment options that you choose from those available in the plan.

Material duties: for the purposes of the STD and LTD programs, the essential tasks, functions and operations, and the skills, abilities, knowledge, training, and experience generally required by employers from those engaged in a particular occupation.

Maturity: the date on which a debt (bond) must be paid.

Medical Plan: The Ryder System, Inc. Medical Plan, also referred to as the Plan.

Mental illness: for the purposes of the STD plan, any psychological, behavioral, or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorder, but excluding demonstrable structural brain damage.

Monthly LTD benefit: a monthly sum payable to you while you are disabled. The maximum monthly benefit is \$8,000. The minimum monthly benefit is \$100.

Monthly income loss: the difference of your pre-disability earning minus your current monthly earnings.

Mutual fund: an investment in which your money is pooled with money from other investors and a professional money manager buys and sells securities with the money to earn a profit for investors.

Net Asset Value (NAV): the price or market value of an individual share of a mutual fund. NAV is calculated at the end of every business day by adding the value of all the securities and cash in the mutual fund's portfolio, subtracting the fund's liabilities, and dividing that amount by the number of shares the fund has issued.

Network benefits: benefits for covered health services that are provided by a network provider or a

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network provider's office or at a network facility, also known as In-Network benefits.

Non-duplication of benefits: in situations where both you and your spouse have health care coverage, your coverage is coordinated with the other insurance plan so that benefits are not duplicated. The combined benefit will not be more than the total expenses recognized under these plans. If children are covered under both parents' health plans, the birthday rule is used to prevent duplication of benefits.

Non-network provider: a health care professional who has not contracted with a network to render treatment or services under the plan.

Orthodontia treatment lifetime maximum: the lifetime maximum the plan will pay for orthodontia treatment per participant. Benefits paid are included in the annual maximum.

Other income benefit: the amount of any benefit for loss of income, provided to you or your family, as a result of the period of disability for which you are claiming benefits from the Ryder LTD plan.

Out-of-Network benefits: benefits for covered health services that are provided by or directed by a non-network physician either at a network facility or at a non-network facility.

Out-of-Network provider: a health care professional who has not contracted with a network to render services under the any of the health insurance plans.

Out-of-pocket maximum: the limit on your cost for covered charges each calendar year. The amounts vary for in-network and non-network options. The out-of-pocket maximum includes the annual deductible, but does not include copays. The out-of-pocket maximum is the most an individual or family will pay in a given calendar year for deductibles and coinsurance under the Medical Plan for eligible, covered charges.

Own occupation: under the LTD plan, means the occupation you were performing when your Disability or Partial disability began. For the purposes of determining Disability under this policy, the insurance carrier will consider your occupation as it is normally performed in the national economy.

Partial disability/partially disabled: under the STD plan, you are considered partially disabled if, immediately following a period of total disability for which you were eligible to receive a weekly benefit, you are:

- still prevented by the same disabling condition from performing essential duties of your occupation; but
- you have recovered to the extent you are:
 - able to perform some, but not all, of the essential duties of your or any occupation; and
 - as a result, you are earning more than 20% but no more than 80% of your pre-disability weekly earnings.

Participating provider: for the Dental Plan, a licensed general practitioner who has signed an agreement with the Cigna Dental plan under which they agree to provide dental care services.

Patient charge schedule: a list of covered benefits and charges applicable under the Cigna Managed Dental Plan.

Physical disease: an entity or process that produces structural or functional changes in your body as diagnosed by a physician.

Physician: for the purposes of the medical, STD and LTD plans, a licensed practitioner of the healing arts acting within the scope of his or her license. Covered physicians include: (This list is all inclusive.)

- a medical doctor (MD) or surgeon;
- an osteopath, podiatrist, or chiroprapist;

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- a chiropractor, except that services are limited to the correction and treatment of the extremities and/or a subluxation of the spine;
- a nurse midwife under the supervision of a physician;
- physical therapist;
- psychologist or psychiatrist;
- dentist or oral surgeon; or
- acupuncturist.

Note: Specifically excluded from this definition are naturopaths, religion-affiliated practitioners, optometrists, and opticians, whether or not licensed under any legal authority.

Plan administrator: the named fiduciary within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) appointed under the plan with the authority to control and manage the operation and administration of the plan. The Plan Administrator for the Ryder System, Inc. employee benefit plans is the Vice President of the Compensation and Benefits, except that the Plan Administrator of the 401(k) Savings Plan and the Retirement Plan is the Ryder Retirement Committee.

Plan payment: the amount the plan pays for covered services. The amount depends on the type of service received and the benefit option you elect.

Post-tax: money that is deducted from your paycheck after Social Security, federal and most state income taxes are deducted.

Predetermination of benefits: an estimate supplied by the benefits administrator of the amount of benefit the dental plan will pay toward a specified course of treatment.

Pre-existing condition: for the purposes of the STD and LTD plans, a pre-existing condition is a mental or physical condition for which you have consulted a physician or received medical treatment or services, for during the 3-month period just before the date your STD and/or LTD coverage becomes effective. You are not covered for a disability caused or contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition unless, on the date you become disabled, you:

- have been continuously insured under the plan for at least 12 months; and
- have been actively at work for at least one full day after the end of those 12 months.

Routine follow up care to determine whether breast cancer has reoccurred if you have previously been determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the follow up care.

Preferred Provider Organization (PPO): a group of hospitals and physicians who contract with the benefits administrator to provide health care services under the laws of the state where its service areas are located.

Pre-tax: money deducted from your paycheck before Social Security, federal and most state income taxes are deducted except that, in the 401(k) Savings Plan, your pre-tax contributions are subject to Social Security and certain other employment taxes.

Proof of good health: also known as evidence of insurability as required by the life and disability claims administrator when increases in coverage are requested at annual enrollment or at other times as appropriate.

Prospectus: provides investors with a thorough description of a mutual fund or stock, including an explanation of the fund's objective, how money is invested, and the fees and expenses associated with the fund.

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Qualified Life Event: any of the following events that affect both the need for benefits and the participant's financial ability to provide those benefits. The Internal Revenue Service defines Qualified Life Event. They include, but are not limited to, the following:

- marriage or divorce of the employee;
- birth or adoption of a child;
- death of a spouse or other dependent;
- spouse's gain or loss of employment;
- employee's or spouse's change in employment status from full-time to part-time (or vice versa);
- employee or spouse taking an unpaid leave of absence;
- a significant change in health care coverage or cost of coverage for employee and/or spouse that is attributable to spouse's employment; and
- other events that are approved by the plan administrator and are consistent with IRS statutes or regulations.

Qualified Domestic Relations Order (QDRO): a court order or judgment that meets specific requirements to pay all or a portion of your savings plan benefits to a former spouse or dependent.

Rollover: a transfer of money from one tax-qualified savings or 401(k) plan to another.

S&P 500: a market value-weighted index created by Standard & Poor's covering the stock of 500 utility, industrial, transportation, and financial companies.

Savings plan: The Ryder System, Inc. 401(k) Savings Plan. Also referred to as the 401(k) plan or the Savings Plan.

Securities: refers to all investments, including stocks, bonds, short-term securities, and shares of mutual funds.

Sickness: disability is deemed to be caused by sickness, rather than accident, if it is caused or contributed by: any condition, disease, or disorder of the body or mind; any infection, except a pus-forming infection of an accidental cut or wound; hernia of any type; any disease of the heart; mental illness; substance abuse; or pregnancy.

Stock (equity): a unit of ownership sold by a company that sells stock to raise money. When you buy stocks, you become an owner of a piece of the company.

Substance abuse: for the purposes of the STD and LTD plans, a pattern of pathological use of alcohol, other psychoactive drugs, and substances characterized by:

- impairments in social and/or occupational functioning;
- debilitating physical condition;
- inability to abstain from or reduce consumption of the substance; or
- the need for daily substance use to maintain adequate functioning.

Substance Use Disorders Services: Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Tax-deferred contributions: the before-tax amount a participant elects to contribute to the 401(k) Savings Plan. Tax-deferred contributions are not subject to federal income taxes when deposited into the

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401(k) Savings Plan. However, these contributions are subject to federal income tax when withdrawn from the plan.

Tax-qualified plan: one that meets certain IRS requirements and is eligible for special tax advantages, such as tax-deferred contributions and earnings.

Terminally ill/terminal illness: an individual who has a life expectancy of 12 months or less.

Total disability/totally disabled: for the purposes of the LTD plan, means that you are prevented by: accidental bodily injury; sickness; mental illness; substance abuse; or pregnancy, from performing the essential duties of your occupation, and as a result, you are earning less than 20% of your pre-disability weekly earnings.

Unproven Services: health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received. Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent Care: care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center: a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and prevailing charge: the charge for services, treatments, supplies, or medications essential to the care of the covered individual, which are the lesser of:

- the actual charges for such services, treatments, supplies or medications; or
- the amount normally charged for comparable services, treatments, supplies or medications by most providers in the locality where the charges were incurred when furnished to an individual of the same sex and age for a similar sickness or injury.

The benefits administrator determines the allowable amount for each service, treatment, supply or medication.

Vesting (Vested): the process by which you gain ownership of Company contributions to the 401(k) Savings Plan. You are vested after you have completed 60 or more months of service with Ryder. You are always 100% vested in your contributions to the plan.

Year of service: a calendar year of employment in which you work at least 1,000 hours. An employee's first year of service shall be the one-year period beginning on his first date of employment, for purposes of determining eligibility for participation in the 401(k) Savings Plan.

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Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD

I. ARTICLE - INTRODUCTION

Ryder System, Inc. (the "Company") established the Ryder Severance Plan (the "Plan"), effective as of January 1, 2007 and as amended and restated as of June 1, 2010, to provide temporary and short-term unemployment type benefits to certain employees of the Company and its participating affiliates who suffer a loss of employment under the terms and conditions set forth in the Plan. The Plan is hereby amended and restated effective as of January 1, 2014. The Plan replaces and supersedes any and all severance plans, policies, guidelines and/or practices of the Company and its participating affiliates in effect for their employees prior to January 1, 2014, and such other plans, policies, guidelines and/or practices are amended to effectuate the foregoing, with the exception of any individual written agreement between an employee and the Company regarding severance benefits. The Plan is intended to fall within the definition of an "employee welfare benefit plan" under Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan may not be amended except in accordance with the terms set forth below.

Please note that the existence of this Plan in no way alters or modifies any other terms of an individual's employment with the Employer.

II. ARTICLE - DEFINITIONS AND INTERPRETATIONS

The following definitions and interpretations of important terms apply to the Plan.

1. **Base Pay.** For purposes hereof, Base Pay shall mean such person's basic hourly rate from his or her Employer as of the date of his or her Termination of Employment multiplied by the normal hours the Employee was regularly scheduled to work. Base Pay shall be determined as reflected on the applicable Employer's payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation or other additional compensation. For purposes hereof, an Employee's Base Pay shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended.
2. **Base Salary.** For purposes hereof, Base Salary shall mean such person's base salary or wages from his or her Employer as of the date of his or her Termination of Employment. Base Salary shall be determined as reflected on the applicable Employer's payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation, COLA, hardship pay, assignment premiums (if not included in base pay), or other additional compensation. For purposes hereof, an Employee's Base Salary shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended (the "Code").
3. **Company.** Ryder System, Inc.
4. **Effective Date.** January 1, 2014.
5. **Employee.** Any regular full-time employee of the Employer who works in the United States (including eligible expatriates, and excluding employees based in Puerto Rico) other than: (i) an

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individual who is entitled to similar severance-type or termination benefits or has entered into a written agreement with the Company or an affiliate, predecessor or successor of the Company that provides the individual with severance, termination, or any similar benefits payable in the event of his or her termination of employment; (ii) any designated employee represented by a union or covered by a collective bargaining agreement; (iii) any non-officer eligible for severance-like compensation; (iv) any driver or warehouse worker; (v) any supply chain worker hired or rehired on or after January 1, 2013 and covered under the Ryder Severance Plan for Eligible Supply Chain Employees (as such Plan may be amended from time to time) or (vi) any employees hired on the Company's General Motors Lead Logistics Provider account on or after May 31, 2010. The term "Employee" shall also not include any individual (i) designated by the Employer as an independent contractor and not as an employee at the time of any determination, (ii) being paid by or through an employee leasing company or other third party agency, (iii) designated by the Employer as a freelance worker and not as an employee at the time of any determination, (iv) designated by the Employer as a seasonal, occasional, casual, limited duration, or temporary employee, during the period the individual is so paid or designated, or (v) designated by the Employer as a leased employee, during the period the individual is so paid or designated; and any such individual listed in (i), (ii), (iii), (iv) or (v) shall not be an Employee even if he or she is later retroactively reclassified as a common-law employee of the Employer during all or any part of such period pursuant to applicable law or otherwise.

6. Employer. The Company and each affiliate or subsidiary of the Company that participates in the Plan with the approval of the Company's Board of Directors.

7. Just Cause. Any one of the following reasons for the discharge or other separation of an Employee from employment with an Employer:

- (i) any act or omission by the Employee resulting or intended to result in personal gain at the expense of any Employer;
- (ii) the improper disclosure by the Employee of proprietary or confidential information, or trade secrets of any Employer, including, without limitation, pricing information, client lists, or business processes;
- (iii) misconduct by the Employee, including, but not limited to:
 - fraud,
 - intentional violation of or negligent disregard for the rules and procedures of the Employer or actions or inactions resulting in harm to the Employer (including a violation of the Employer's Principles of Business Conduct, the Employer's Employee Handbook, or any other policy or practice of the Employer),
 - insubordination,
 - theft,
 - violent acts or threats of violence,
 - conviction of a felony,
 - conviction of a misdemeanor with a nexus to the Employee's employment,
 - breach of trust or dishonesty, or
 - unauthorized possession or use of alcohol or controlled substances on the property of the Employer or unauthorized use of alcohol or controlled substances while on business for the Employer. The determination of whether an Employee has engaged in unauthorized use of alcohol while on business for the Employer will be determined by the Plan Administrator in its sole and absolute discretion;
- (iv) excessive absenteeism or lateness which does not qualify as legitimate time off pursuant to any rights under federal or state law;
- (v) poor job performance;
- (vi) any other act that the Employer shall deem detrimental to the Company.

The determination of whether a discharge or other separation from employment is for Just Cause shall be made by the Plan Administrator, in its sole and absolute discretion, and such determination shall be conclusive and binding on the affected Employee.

8. Participant. An Employee who meets the requirements for eligibility under the Plan, as set forth in Article III of the Plan. An individual shall cease being a Participant once all benefits payable to

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such individual under the Plan have been completed (or earlier upon the death of the Participant) and no person shall have any further rights under this Plan with respect to such former Participant.

9. Plan Administrator. The Plan Administrator shall be the Chief Administrative Officer.

10. Termination of Employment.

A. The termination by the Employer of an Employee's employment relationship with the Employer as the result of a bona fide job elimination. Notwithstanding the foregoing, a bona fide job elimination will not be considered a Termination of Employment if:

(i) an Employee is offered, but refuses, employment with the Employer, its businesses or its affiliated companies (or a joint venture owned by any such entity) in a position that provides the Employee with substantially equivalent base pay and job responsibilities (unless the position requires the Employee to unreasonably relocate), as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence including but not limited to job descriptions, offer letters, and pay records.

(ii) an Employee works in a business (or the portion of such business) of the Employer (a) which is sold in whole or in part to another corporation or company, whether by sale of stock or assets, (b) which is merged or consolidated with another corporation or company or is part of a similar corporate transaction or (c) which is outsourced, insourced, or otherwise transferred or lost to another corporation or company including, but not limited to, the customer, a purchaser, surviving business, competitor, vendor, supplier, or temporary agency, (the "New Employer"), and the Employee is offered employment, whether temporary, part time or full time with the New Employer whether or not s/he accepts any such position and whether or not the offer occurs prior to or during the term of the severance period in a position that provides the Employee with substantially equivalent base pay and job responsibilities and does not require the Employee to unreasonably relocate, as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence, including but not limited to job descriptions, offer letters, and pay records. Decisions by the Plan Administrator are final. For the avoidance of doubt, any short term or temporary assignment with the New Employer during the transition period will disqualify the Employee from receiving severance benefits.

B. Termination of Employment shall not include any discharge or other separation of employment other than for those reasons enumerated in section 11.A. Nor, by way of example, will a Termination of Employment occur under any of the following circumstances:

- (i) for Just Cause;
- (ii) an Employee's voluntary resignation, job abandonment, or retirement;
- (iii) death or disability of the Employee; or
- (iv) the Employee fails to return to active employment after a cessation of disability or following a termination of an approved leave of absence.

An indefinite or temporary layoff or reduction in force does not constitute a Termination of Employment unless the layoff or reduction in force is permanent. The determination as to whether a layoff or reduction in force is permanent shall be made by the Plan Administrator at the time of such layoff or reduction in force, in its sole and absolute discretion, and such determination shall be final and binding on all affected Employees. An Employee's Termination of Employment shall occur on the last day of his or her employment with the Employer.

11. Years of Service. A Year of Service shall be measured as a full 12 month consecutive period. No credit shall be provided for any fraction of a Year of Service. The Years of Service shall be based upon the Employee's adjusted hire date, as indicated in the Employer's records. If an Employee is rehired after having received any severance benefits under this Plan or any other plan or program, the Years of Service shall be based upon his or her latest date of hire.

RYDER SEVERANCE PLAN**III. ARTICLE - ELIGIBILITY FOR SEVERANCE BENEFITS**

An Employee becomes eligible for severance under the Plan (i.e., becomes a "Participant") if such Employee: (i) either (A) experiences a Termination of Employment, or (B) is notified in writing that the Plan Administrator, in its sole and absolute discretion, has decided to grant the Employee eligibility hereunder, and (ii) satisfies the conditions of Article IV.

IV. ARTICLE - CONDITIONS TO RECEIVE SEVERANCE BENEFITS

Notwithstanding anything herein to the contrary, severance benefits shall be paid under the Plan in consideration of the Employee executing an agreement and general release in such form acceptable to the Company, in its sole discretion, under which, among other things, the Employee releases and discharges the Employer from all claims and liabilities relating to the Employee's employment with the Employer and/or the termination of the Employee's employment, including without limitation, any claims under any federal, state or local statute or ordinance, including but not limited to those under the Age Discrimination in Employment Act of 1967. An Employee shall become a Participant and payment of severance under the Plan will be paid only after the agreement and general release has been signed and the time for the Employee to revoke the agreement and general release, if any, has expired (the "Release Effective Date").

V. ARTICLE - THE AMOUNT OF SEVERANCE BENEFITS

1. Severance Pay. A Participant will be entitled to receive severance pay under the Plan based on the Participant's position with the Employer immediately prior to the Termination of Employment and the Participant's Years of Service with the Employer as set forth in Schedule A. The Employer has no obligation to re-hire any Participant who received severance. If a Participant is rehired by the Employer while still receiving severance benefits under this Plan, any severance benefits then payable to the Participant shall cease upon the date of rehire. The Employer reserves the right to deduct from the severance pay any salary or incentive overpayments or other amounts improperly or inadvertently paid to the Participant during the course of employment, unless such deduction is otherwise prohibited by law or in violation of Section 409A of the Code.
2. Extension of Benefits. In connection with a termination of employment, Participants (and their eligible dependents) may be entitled to elect to continue coverage under the Company's group medical, prescription, vision and dental insurance plans and the Company's Health Care Reimbursement Account on a self-pay basis in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") if the Participant was a participant in such plans as of his or her termination date. If an Employee becomes a Participant and elects COBRA coverage for him or herself and/or his or her eligible dependents, the Company will pay a portion of the COBRA premiums for the number of weeks the Participant is entitled to severance pay under the Plan, except that the Company will not pay any portion of the COBRA premiums for drivers or warehouse workers. Specifically, for such period, the Company will reduce the COBRA premiums by the amount it pays at such time for active employees' insurance premiums. The Participant will be responsible for the remaining amount of the COBRA premium. All other provisions of Participants' COBRA coverage will be in accordance with the applicable plan in effect for active employees of the Company (including any applicable co-payments, deductibles and other out-of-pocket expenses). Participants should refer to the Company's group medical, prescription and dental plans and Health Care Reimbursement Account Plan for additional information regarding their rights and obligations under COBRA.

Participants who are covered by a company-plan that does not meet the minimum essential health coverage of the Affordable Care Act are not eligible for benefits continuance under COBRA.

3. No Continuation of Non-COBRA Benefits. Participation in any Company short term disability plan, long term disability plan, employee stock purchase plan, accidental death and dismemberment plan, life insurance and/or additional life insurance plan, Dependent Care Reimbursement Account or business travel accident plan will end as of the Termination of Employment date. Participants should refer to the plan documents for the life insurance plan to determine applicable conversion

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rights. Coverage under the Company's legal plan will end as of the last day of the month in which the Termination of Employment date occurs. Participation in any other benefits under the Company's health, welfare or retirement benefits plans will end as of the Termination of Employment date.

4. Non-Duplications of Benefits. If a Participant receives severance benefits under the Plan, such Participant shall not be entitled to receive any other severance, separation, notice or termination payments on account of his or her employment with the Employer under any other plan, policy, program or agreement, except as provided in the agreement and general release referenced in Article IV of the Plan or otherwise prohibited by Section 409A of the Code. If, for any reason, a Participant becomes entitled to or receives any other severance, separation, notice or termination payments on account of his or her employment or Termination of Employment with the Employer, including, for example, any payments required to be paid to the Participant under any Federal, State or local law or pursuant to any agreement (except unemployment benefits payable in accordance with state law and payment for accrued but unused vacation and benefits as described in the release), his or her severance under the Plan will be reduced by the amount of such other payments paid or payable, to the extent permitted by Section 409A of the Code. A Participant must notify the Plan Administrator if he or she receives or is claiming to be entitled to receive any such payment(s).

VI. ARTICLE - HOW AND WHEN SEVERANCE WILL BE PAID

Severance pay under the Plan will be paid to a Participant in the form of periodic installments in accordance with Schedule A hereto; provided that, the Plan Administrator, in its sole and absolute discretion, may provide severance pay to a Participant in the form of a single lump sum payment to the extent permitted under Section 409A of the Internal Revenue Code. Notwithstanding anything in the Plan to the contrary, no severance payments will be made to a Participant after December 31 of the second calendar year following the calendar year in which the Termination of Employment occurs.

VII. ARTICLE - MISCELLANEOUS PROVISIONS

1. Amendment and Termination. The Company reserves the right, in its sole and absolute discretion, to terminate, amend or modify the Plan, in whole or in part, at any time and for any reason. If the Plan is terminated, amended or modified, an individual's right to participate in, or to receive severance benefits under, the Plan may be changed; provided, however, that severance payable to a Participant who has incurred a Termination of Employment prior to such termination, amendment or modification of the Plan, shall not be reduced by the termination, amendment or modification.
2. No Additional Rights Created. Neither the establishment of this Plan, nor any modification thereof, nor the payment of any severance benefits hereunder, shall be construed as giving to any Participant, Employee (or any beneficiary of either), or other person any legal or equitable right against the Employer or any officer, director or employee thereof; and in no event shall the terms and conditions of employment by the Employer of any Employee be modified or in any way affected by this Plan.
3. Records. The records of the Employer with respect to Years of Service, employment history, base pay, absences, and all other relevant matters shall be conclusive for all purposes of this Plan.
4. Construction. The respective terms and provisions of the Plan shall be construed, whenever possible, to be in conformity with the requirements of ERISA, or any subsequent laws or amendments thereto. To the extent not in conflict with the preceding sentence or another provision in the Plan, the construction and administration of the Plan shall be in accordance with the laws of the State of Florida applicable to contracts made and to be performed within the State of Florida (without reference to its conflicts of law provisions).
5. Severability. Should any provisions of the Plan be deemed or held to be unlawful or invalid for any reason, such fact shall not adversely affect the other provisions of the Plan unless such determination shall render impossible or impracticable the functioning of the Plan, and in such

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case, an appropriate provision or provisions shall be adopted so that the Plan may continue to function properly.

6. Incompetency. In the event that the Plan Administrator finds that a Participant is unable to care for his or her affairs because of illness or accident, then the severance benefits payable hereunder, unless claim has been made therefore by a duly appointed guardian, committee, or other legal representative, may be paid in such manner as the Plan Administrator shall determine, to the extent permitted by Section 409A of the Code, and the application thereof shall be a complete discharge of all liability for any payments or severance benefits to which such Participant (or designated beneficiary) was or would have been otherwise entitled under this Plan.
7. Plan Not a Contract of Employment. Nothing contained in this Plan shall be held or construed to create any liability upon the Employer to retain any Employee in its service. All Employees shall remain subject to discharge or discipline to the same extent as if the Plan had not been put into effect. An individual who is receiving severance under this Plan shall not be considered an Employee immediately upon his or her Termination of Employment.
8. Financing. The severance benefits payable under this Plan shall be paid out of the general assets of the Company. No Participant or any other person shall have any interest whatsoever in any specific asset of any Employer. To the extent that any person acquires a right to receive payments under this Plan, such right shall not be secured by any assets of any Employer.
9. Nontransferability. In no event shall the Company (or any other Employer) make any payment under this Plan to any assignee or creditor of a Participant, except as otherwise required by law. Prior to the time of a payment hereunder, a Participant shall have no rights by way of anticipation or otherwise to assign or otherwise dispose of any interest under this Plan, nor shall rights be assigned or transferred by operation of law.
10. Tax Matters. All payments made hereunder shall be subject to applicable tax and other withholding as determined by the Company.
11. Section 409A of the Code. Notwithstanding anything herein to the contrary, the Company shall have the right to defer a payment hereunder so as to avoid negative tax consequences under Section 409A of the Code, and such payment shall be made on the first day on which no negative tax consequences will be imposed on the Participant under Section 409A. No payments shall be made hereunder unless a Participant's Termination of Employment constitutes a "separation from service" as defined by Section 409A of the Code and the regulations issued thereunder. For purposes of determining whether a "separation from service" has occurred, pursuant to Treas. Reg. §1.409A-1(h)(3), the Company has elected to use "at least 80 percent" each place it appears in Sections 1563(a)(1), (2), and (3) of the Code and in Treas. Reg. §1.414(c)-2. Severance payments hereunder are intended to constitute separation pay due to an involuntary separation from service under Section 409A.

VIII. ARTICLE - WHAT ELSE A PARTICIPANT NEEDS TO KNOW ABOUT THE PLAN

1. Claim Procedure. An individual or his or her beneficiary (if applicable) may file a written claim with the Plan Administrator with respect to his or her rights to receive a benefit from the Plan. The claimant will be informed of the decision of the Plan Administrator with respect to the claim within 90 days after it is filed. Under special circumstances, the Plan Administrator may require an additional period of not more than 90 days to review a claim. If this occurs, the claimant will be notified in writing as to the length of the extension, the reason for the extension, and any other information needed in order to process the claim. If the claimant is not notified within the 90-day (or 180-day, if so extended) period, he or she may consider the claim to be denied.

If a claim is denied, in whole or in part, the claimant will be notified in writing of the specific reason(s) for the denial, the exact plan provision(s) on which the decision was based, what additional material or information is relevant to his or her case, and what procedure the claimant should follow to get the claim reviewed again. The claimant then has sixty (60) days to appeal the decision to the Plan Administrator.

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The appeal must be submitted in writing to the Plan Administrator. A claimant may request to review pertinent documents, and may submit a written statement of issues and comments.

A decision as to a claimant's appeal will be made within sixty (60) days after the appeal is received. Under special circumstances, the Plan Administrator may require an additional period of not more than 60 days to review an appeal. If this occurs, the claimant will be notified in writing as to the length of the extension, not to exceed 120 days from the day on which the appeal was received.

If a claimant's appeal is denied, in whole or in part, he or she will be notified in writing of the specific reason(s) for the denial and the exact plan provision(s) on which the decision was based. The decision on an appeal of the Plan Administrator will be final and binding on all parties and persons affected thereby. If a claimant is not notified within the 60-day (or 120-day, if so extended) period, he or she may consider the appeal as denied.

2. Plan Interpretation and Benefit Determination. The Plan is administered and operated by the Plan Administrator who has complete authority, with respect to matters within its jurisdiction, in its sole and absolute discretion, to construe the terms of the Plan (and any related or underlying documents or policies), and to determine the eligibility for, and amount of, severance benefits due under this Plan to Participants and their beneficiaries. All such interpretations and determinations (including factual determinations) of the Plan Administrator shall be final and binding upon all parties and persons affected thereby. The Plan Administrator may appoint one or more individuals and delegate such of its powers and duties as it deems desirable to any such individual(s), in which case every reference herein made to the Plan Administrator shall be deemed to mean or include the appointed individual(s) as to matters within their jurisdiction.
3. Participants' Rights Under ERISA. Participants of the Plan are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report if the Plan covers 100 or more people. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries. No one, including the Company or any other person, may fire an employee or otherwise discriminate against an employee in any way to prevent him/her from obtaining a benefit or exercising his/her rights under ERISA. If a Participant's claim for a benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. Participants have the right to have the Plan Administrator review and reconsider their claims. Under ERISA, there are steps that Participants can take to enforce the above rights.

For instance, if a Participant requests materials from the Plan Administrator and does not receive them within 30 days, he/she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to \$110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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If a Participant has a claim for severance benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or federal court. If he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant has sued to pay these costs and fees. If the Participant loses, the court may order him/her to pay these costs and fees, for example, if it finds the claim is frivolous. If a Participant has any questions about the Plan, he/she should contact the Plan Administrator. Any questions about this statement or about any rights under ERISA should be directed to the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

4. Plan Document. This document shall constitute the plan document and summary plan description of the Plan.
5. Other Important Facts:

OFFICIAL NAME OF THE PLAN:	Ryder Severance Plan
SPONSOR:	Ryder System, Inc. 11690 NW 105 St. Miami, FL 33178 305.500.3726
EMPLOYER IDENTIFICATION NUMBER (EIN):	59-0739250
PLAN NUMBER:	526
TYPE OF PLAN:	Employee Welfare Severance Benefit Plan
END OF PLAN YEAR:	December 31 st
TYPE OF ADMINISTRATION:	Employer Administered
PLAN ADMINISTRATOR:	Chief Administrative Officer 11690 NW 105 St. Miami, Florida 33178 305.500.4743
AGENT FOR SERVICE OF LEGAL PROCESS:	Executive Vice President – General Counsel 11690 NW 105 St. Miami, Florida 33178 305.500.7797

RESTATEMENT EFFECTIVE DATE: January 1, 2014

The Plan Administrator keeps records of the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions that an individual may have about the Plan.

Service of legal process may be made upon the Plan Administrator.

No individual may, in any case, become entitled to additional severance benefits or other rights under this Plan after the Plan is terminated. Under no circumstances, will any benefit under this Plan ever vest or become nonforfeitable, except as provided in Section 1 of Article VII.

RYDER SEVERANCE PLAN

Severance pay is subject to Federal and state income and Social Security tax withholdings and any other withholdings mandated by law.

For All Participants

Vacation. All Participants receive earned but unused vacation in accordance with the Company's vacation policy.

Outplacement. Outplacement services will be paid by the Company on a Participant's behalf in an amount to be determined at the Plan Administrator's sole discretion.

These are the only Severance Benefits to which a Participant is entitled except as provided in Sections 2 and 3 of Article V. No other fringe benefits, including, but not limited to, car allowances, outplacement incidentals, cell phones allowances, or other perquisites are to be paid as severance.

SCHEDULE A**Eligible Non-Exempt and Hourly Employees****One week Base Pay per Year of Service for first 10 years, plus**

Two weeks Base Pay per Years of Service over 10 years

Minimum: 2 weeks Base Pay

Maximum: 36 weeks Base Pay

Participants with less than one (1) Year of Service receive two (2) weeks of Base Pay.

Eligible Exempt and Salary Non-Exempt Employees**MS 01-07, SN01-06, SA 10, 63, 64, 65, 66, 67, 72, 75, 77, IT 30-31 and AA01, 02**

One week Base Salary per Year of Service for first 10 years, plus

Two weeks Base Salary per Years of Service over 10 years

Minimum: 4 weeks base salary

Maximum: 36 weeks base salary

MS 08-09, IT-32 and SA 12, 13, 18, 43, 68, 70, 79

One week Base Salary per Year of Service for first 10 years, plus

Two weeks Base Salary per Years of Service over 10 years

Minimum: 8 weeks base salary

Maximum: 36 weeks base salary

MS 10, IT-33 and SA44

One week Base Salary per Year of Service for first 10 years, plus

Two weeks Base Salary per Years of Service over 10 years

Minimum: 12 weeks base salary

Maximum: 36 weeks base salary

MS 11-13, and SA16, 17, 19, 38, 46, 47, 48, 49, 89

One week Base Salary per Year of Service for first 10 years, plus

Two weeks Base Salary per Years of Service over 10 years

Minimum: 26 weeks base salary

Maximum: 39 weeks base salary

Directors must be employed by the Company for one year to be eligible for severance.

Revised: January 1, 2014

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

on

Ryder System, Inc. reserves the right, in its sole discretion, to modify, change, revise, amend or terminate any benefit program sponsored by it at any time, for any reason and without prior notice as it relates to the provision of benefits for any active or former employee, including any beneficiary or dependent of such active or former employee in whole or in part. Ryder System, Inc.'s right to amend or terminate any benefit program includes, but is not limited to, changes in any applicable eligibility requirements, premiums, or other employee payments charged or benefits provided.

Employees who work under the provisions of certain collective bargaining agreements may be covered under different benefit provisions than those described in this SPD.

I. ARTICLE - INTRODUCTION

Ryder System, Inc. (the "Company") established the Ryder Severance Plan for Eligible Supply Chain Employees (the "Plan"), effective as of January 1, 2014, to provide temporary and short-term unemployment type benefits to certain supply chain employees of the Company and its participating affiliates who are hired or rehired on or after January 1, 2013 and who suffer a loss of employment under the terms and conditions set forth in the Plan. The Plan replaces and supersedes any and all severance plans, policies, guidelines and/or practices of the Company and its participating affiliates in effect for their applicable supply chain employees prior to the effective date of this Plan, and such other plans, policies, guidelines and/or practices are amended to effectuate the foregoing, with the exception of any individual written agreement between an employee and the Company regarding severance benefits. The Plan is intended to fall within the definition of an "employee welfare benefit plan" under Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan may not be amended except in accordance with the terms set forth below.

Please note that the existence of this Plan in no way alters or modifies any other terms of an individual's employment with the Employer.

II. ARTICLE - DEFINITIONS AND INTERPRETATIONS

The following definitions and interpretations of important terms apply to the Plan.

1. Base Pay. For purposes hereof, Base Pay shall mean such person's basic hourly rate from his or her Employer as of the date of his or her Termination of Employment multiplied by the normal hours the Employee was regularly scheduled to work. Base Pay shall be determined as reflected on the applicable Employer's payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation or other additional compensation. For purposes hereof, an Employee's Base Pay shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended.
2. Base Salary. For purposes hereof, Base Salary shall mean such person's base salary or wages from his or her Employer as of the date of his or her Termination of Employment. Base Salary shall be determined as reflected on the applicable Employer's payroll records, and shall not include bonuses, overtime pay, shift premiums, commissions, employer contributions for benefits, incentive or deferred compensation, COLA, hardship pay, assignment premiums (if not included in base pay), or other additional compensation. For purposes hereof, an Employee's Base Salary shall include any salary reduction contributions made on his or her behalf to any tax deferred savings plan or any other plan of an Employer under Section 125 or 401(k) of the Internal Revenue Code of 1986, as amended (the "Code").
3. Company. Ryder System, Inc.
4. Effective Date. January 1, 2014.

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

5. Employee. Any regular full-time employee of the Employer (whether exempt, non-exempt or hourly) who works in the United States (including eligible expatriates and excluding employees based in Puerto Rico) and who: (i) was hired or rehired on or after January 1, 2013; (ii) works within the supply chain business of the Employer; and (iii) is designated to be within management levels MS01 - MS07 or equivalent SA, IT and AA positions as outlined on Schedule A or is a non-exempt or hourly worker. The term "Employee" shall exclude (a) all other employees of the Employer, (b) drivers and warehouse workers, and (c) employees hired on the Company's General Motors Lead Logistics Provider account on or after May 31, 2010. The term "Employee" shall also exclude any individual (i) designated by the Employer as an independent contractor and not as an employee at the time of any determination, (ii) being paid by or through an employee leasing company or other third party agency, (iii) designated by the Employer as a freelance worker and not as an employee at the time of any determination, (iv) designated by the Employer as a seasonal, occasional, casual, limited duration, or temporary employee, during the period the individual is so paid or designated, or (v) designated by the Employer as a leased employee, during the period the individual is so paid or designated; and any such individual listed in (i), (ii), (iii), (iv) or (v) shall not be an Employee even if he or she is later retroactively reclassified as a common-law employee of the Employer during all or any part of such period pursuant to applicable law or otherwise.
6. Employer. The Company and each affiliate or subsidiary of the Company that participates in the Plan with the approval of the Company's Board of Directors.
7. Just Cause. Any one of the following reasons for the discharge or other separation of an Employee from employment with an Employer:
- (i) any act or omission by the Employee resulting or intended to result in personal gain at the expense of any Employer;
 - (ii) the improper disclosure by the Employee of proprietary or confidential information, or trade secrets of any Employer, including, without limitation, pricing information, client lists, or business processes;
 - (iii) misconduct by the Employee, including, but not limited to:
 - fraud,
 - intentional violation of or negligent disregard for the rules and procedures of the Employer or actions or inactions resulting in harm to the Employer (including a violation of the Employer's Principles of Business Conduct, the Employer's Employee Handbook, or any other policy or practice of the Employer),
 - insubordination,
 - theft,
 - violent acts or threats of violence,
 - conviction of a felony,
 - conviction of a misdemeanor with a nexus to the Employee's employment,
 - breach of trust or dishonesty, or
 - unauthorized possession or use of alcohol or controlled substances on the property of the Employer or unauthorized use of alcohol or controlled substances while on business for the Employer. The determination of whether an Employee has engaged in unauthorized use of alcohol while on business for the Employer will be determined by the Plan Administrator in its sole and absolute discretion;
 - (iv) excessive absenteeism or lateness which does not qualify as legitimate time off pursuant to any rights under federal or state law;
 - (v) poor job performance;
 - (vi) any other act that the Employer shall deem detrimental to the Company.
- The determination of whether a discharge or other separation from employment is for Just Cause shall be made by the Plan Administrator, in its sole and absolute discretion, and such determination shall be conclusive and binding on the affected Employee.
8. Participant. An Employee who meets the requirements for eligibility under the Plan, as set forth in Article III of the Plan. An individual shall cease being a Participant once all benefits payable to

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

such individual under the Plan have been completed (or earlier upon the death of the Participant) and no person shall have any further rights under this Plan with respect to such former Participant.

9. Plan Administrator. The Plan Administrator shall be the Chief Administrative Officer.

10. Termination of Employment.

A. The termination by the Employer of an Employee's employment relationship with the Employer as the result of a bona fide job elimination. Notwithstanding the foregoing, a bona fide job elimination will not be considered a Termination of Employment if:

(i) an Employee is offered, but refuses, employment with the Employer, its businesses or its affiliated companies (or a joint venture owned by any such entity) in a position that provides the Employee with substantially equivalent base pay and job responsibilities (unless the position requires the Employee to unreasonably relocate), as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence including but not limited to job descriptions, offer letters, and pay records.

(ii) an Employee works in a business (or the portion of such business) of the Employer (a) which is sold in whole or in part to another corporation or company, whether by sale of stock or assets, (b) which is merged or consolidated with another corporation or company or is part of a similar corporate transaction or (c) which is outsourced, insourced or otherwise transferred or lost to another corporation or company including, but not limited to, the customer, a purchaser, surviving business, competitor, vendor, supplier, or temporary agency, (the "New Employer"), and the Employee is offered employment, whether temporary, part time or full time with the New Employer whether or not s/he accepts any such position and whether or not the offer occurs prior to or during the term of the severance period in a position that provides the Employee with substantially equivalent base pay and job responsibilities and does not require the Employee to unreasonably relocate, as determined by the Plan Administrator, in its sole and absolute discretion after reviewing documentary and other evidence, including but not limited to job descriptions, offer letters, and pay records. Decisions by the Plan Administrator are final. For the avoidance of doubt, any short term or temporary assignment with the New Employer during the transition period will disqualify the Employee from receiving severance benefits.

B. Termination of Employment shall not include any discharge or other separation of employment other than for those reasons enumerated in section 11.A. Nor, by way of example, will a Termination of Employment occur under any of the following circumstances:

(i) for Just Cause;

(ii) an Employee's voluntary resignation, job abandonment, or retirement;

(iii) death or disability of the Employee; or

(iv) the Employee fails to return to active employment after a cessation of disability or following a termination of an approved leave of absence.

An indefinite or temporary layoff or reduction in force does not constitute a Termination of Employment unless the layoff or reduction in force is permanent. The determination as to whether a layoff or reduction in force is permanent shall be made by the Plan Administrator at the time of such layoff or reduction in force, in its sole and absolute discretion, and such determination shall be final and binding on all affected Employees. An Employee's Termination of Employment shall occur on the last day of his or her employment with the Employer.

11. Years of Service. A Year of Service shall be measured as a full 12 month consecutive period. No credit shall be provided for any fraction of a Year of Service. The Years of Service shall be based upon the Employee's adjusted hire date, as indicated in the Employer's records. If an Employee is rehired after having received any severance benefits under this Plan or any other plan or program, the Years of Service shall be based upon his or her latest date of hire.

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

III. ARTICLE - ELIGIBILITY FOR SEVERANCE BENEFITS

An Employee becomes eligible for severance under the Plan (i.e., becomes a "Participant") if such Employee: (i) either (A) experiences a Termination of Employment, or (B) is notified in writing that the Plan Administrator, in its sole and absolute discretion, has decided to grant the Employee eligibility hereunder, and (ii) satisfies the conditions of Article IV.

IV. ARTICLE - CONDITIONS TO RECEIVE SEVERANCE BENEFITS

Notwithstanding anything herein to the contrary, severance benefits shall be paid under the Plan in consideration of the Employee executing an agreement and general release in such form acceptable to the Company, in its sole discretion, under which, among other things, the Employee releases and discharges the Employer from all claims and liabilities relating to the Employee's employment with the Employer and/or the termination of the Employee's employment, including without limitation, any claims under any federal, state or local statute or ordinance, including but not limited to those under the Age Discrimination in Employment Act of 1967. An Employee shall become a Participant and payment of severance under the Plan will be paid only after the agreement and general release has been signed and the time for the Employee to revoke the agreement and general release, if any, has expired (the "Release Effective Date").

V. ARTICLE - THE AMOUNT OF SEVERANCE BENEFITS

1. Severance Pay. A Participant will be entitled to receive severance pay under the Plan based on the Participant's position with the Employer immediately prior to the Termination of Employment and the Participant's Years of Service with the Employer as set forth on Schedule A. The Employer has no obligation to re-hire any Participant who received severance. If a Participant is rehired by the Employer while still receiving severance benefits under this Plan, any severance benefits then payable to the Participant shall cease upon the date of rehire. The Employer reserves the right to deduct from the severance pay any salary or incentive overpayments or other amounts improperly or inadvertently paid to the Participant during the course of employment, unless such deduction is otherwise prohibited by law or in violation of Section 409A of the Code.
2. Extension of Benefits. In connection with a termination of employment, Participants (and their eligible dependents) may be entitled to elect to continue coverage under the Company's group medical, prescription, vision and dental insurance plans and the Company's Health Care Reimbursement Account on a self-pay basis in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") if the Participant was a participant in such plans as of his or her termination date. If an Employee becomes a Participant and elects COBRA coverage for him or herself and/or his or her eligible dependents, the Participant will be responsible for the full amount of the COBRA premium. All provisions of Participants' COBRA coverage will be in accordance with the applicable plan in effect for active employees of the Company (including any applicable co-payments, deductibles and other out-of-pocket expenses). Participants should refer to the Company's group medical, prescription and dental plans and Health Care Reimbursement Account Plan for additional information regarding their rights and obligations under COBRA.

Participants who are covered by a company-plan that does not meet the minimum essential health coverage of the Affordable Care Act are not eligible for benefits continuance under COBRA.

3. No Continuation of Non-COBRA Benefits. Participation in any Company short term disability plan, long term disability plan, employee stock purchase plan, accidental death and dismemberment plan, life insurance and/or additional life insurance plan, Dependent Care Reimbursement Account or business travel accident plan will end as of the Termination of Employment date. Participants should refer to the plan documents for the life insurance plan to determine applicable conversion rights. Coverage under the Company's legal plan will end as of the last day of the month in which the Termination of Employment date occurs. Participation in any other benefits under the

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

Company's health, welfare or retirement benefits plans will end as of the Termination of Employment date.

4. Non-Duplications of Benefits. If a Participant receives severance benefits under the Plan, such Participant shall not be entitled to receive any other severance, separation, notice or termination payments on account of his or her employment with the Employer under any other plan, policy, program or agreement, except as provided in the agreement and general release referenced in Article IV of the Plan or otherwise prohibited by Section 409A of the Code. If, for any reason, a Participant becomes entitled to or receives any other severance, separation, notice or termination payments on account of his or her employment or Termination of Employment with the Employer, including, for example, any payments required to be paid to the Participant under any Federal, State or local law or pursuant to any agreement (except unemployment benefits payable in accordance with state law and payment for accrued but unused vacation and benefits as described in the release), his or her severance under the Plan will be reduced by the amount of such other payments paid or payable, to the extent permitted by Section 409A of the Code. A Participant must notify the Plan Administrator if he or she receives or is claiming to be entitled to receive any such payment(s).

VI. ARTICLE - HOW AND WHEN SEVERANCE WILL BE PAID

Severance pay under the Plan will be paid to a Participant in the form of periodic installments in accordance with Schedule A hereto; provided that, the Plan Administrator, in its sole and absolute discretion, may provide severance pay to a Participant in the form of a single lump sum payment to the extent permitted under Section 409A of the Internal Revenue Code. Notwithstanding anything in the Plan to the contrary, no severance payments will be made to a Participant after December 31 of the second calendar year following the calendar year in which the Termination of Employment occurs.

VII. ARTICLE - MISCELLANEOUS PROVISIONS

1. Amendment and Termination. The Company reserves the right, in its sole and absolute discretion, to terminate, amend or modify the Plan, in whole or in part, at any time and for any reason. If the Plan is terminated, amended or modified, an individual's right to participate in, or to receive severance benefits under, the Plan may be changed; provided, however, that severance payable to a Participant who has incurred a Termination of Employment prior to such termination, amendment or modification of the Plan, shall not be reduced by the termination, amendment or modification.
2. No Additional Rights Created. Neither the establishment of this Plan, nor any modification thereof, nor the payment of any severance benefits hereunder, shall be construed as giving to any Participant, Employee (or any beneficiary of either), or other person any legal or equitable right against the Employer or any officer, director or employee thereof; and in no event shall the terms and conditions of employment by the Employer of any Employee be modified or in any way affected by this Plan.
3. Records. The records of the Employer with respect to Years of Service, employment history, base pay, absences, and all other relevant matters shall be conclusive for all purposes of this Plan.
4. Construction. The respective terms and provisions of the Plan shall be construed, whenever possible, to be in conformity with the requirements of ERISA, or any subsequent laws or amendments thereto. To the extent not in conflict with the preceding sentence or another provision in the Plan, the construction and administration of the Plan shall be in accordance with the laws of the State of Florida applicable to contracts made and to be performed within the State of Florida (without reference to its conflicts of law provisions).
5. Severability. Should any provisions of the Plan be deemed or held to be unlawful or invalid for any reason, such fact shall not adversely affect the other provisions of the Plan unless such determination shall render impossible or impracticable the functioning of the Plan, and in such

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

case, an appropriate provision or provisions shall be adopted so that the Plan may continue to function properly.

6. Incompetency. In the event that the Plan Administrator finds that a Participant is unable to care for his or her affairs because of illness or accident, then the severance benefits payable hereunder, unless claim has been made therefore by a duly appointed guardian, committee, or other legal representative, may be paid in such manner as the Plan Administrator shall determine, to the extent permitted by Section 409A of the Code, and the application thereof shall be a complete discharge of all liability for any payments or severance benefits to which such Participant (or designated beneficiary) was or would have been otherwise entitled under this Plan.
7. Plan Not a Contract of Employment. Nothing contained in this Plan shall be held or construed to create any liability upon the Employer to retain any Employee in its service. All Employees shall remain subject to discharge or discipline to the same extent as if the Plan had not been put into effect. An individual who is receiving severance under this Plan shall not be considered an Employee immediately upon his or her Termination of Employment.
8. Financing. The severance benefits payable under this Plan shall be paid out of the general assets of the Company. No Participant or any other person shall have any interest whatsoever in any specific asset of any Employer. To the extent that any person acquires a right to receive payments under this Plan, such right shall not be secured by any assets of any Employer.
9. Nontransferability. In no event shall the Company (or any other Employer) make any payment under this Plan to any assignee or creditor of a Participant, except as otherwise required by law. Prior to the time of a payment hereunder, a Participant shall have no rights by way of anticipation or otherwise to assign or otherwise dispose of any interest under this Plan, nor shall rights be assigned or transferred by operation of law.
10. Tax Matters. All payments made hereunder shall be subject to applicable tax and other withholding as determined by the Company.
11. Section 409A of the Code. Notwithstanding anything herein to the contrary, the Company shall have the right to defer a payment hereunder so as to avoid negative tax consequences under Section 409A of the Code, and such payment shall be made on the first day on which no negative tax consequences will be imposed on the Participant under Section 409A. No payments shall be made hereunder unless a Participant's Termination of Employment constitutes a "separation from service" as defined by Section 409A of the Code and the regulations issued thereunder. For purposes of determining whether a "separation from service" has occurred, pursuant to Treas. Reg. §1.409A-1(h)(3), the Company has elected to use "at least 80 percent" each place it appears in Sections 1563(a)(1), (2), and (3) of the Code and in Treas. Reg. §1.414(c)-2. Severance payments hereunder are intended to constitute separation pay due to an involuntary separation from service under Section 409A.

VIII. ARTICLE - WHAT ELSE A PARTICIPANT NEEDS TO KNOW ABOUT THE PLAN

1. Claim Procedure. An individual or his or her beneficiary (if applicable) may file a written claim with the Plan Administrator with respect to his or her rights to receive a benefit from the Plan. The claimant will be informed of the decision of the Plan Administrator with respect to the claim within 90 days after it is filed. Under special circumstances, the Plan Administrator may require an additional period of not more than 90 days to review a claim. If this occurs, the claimant will be notified in writing as to the length of the extension, the reason for the extension, and any other information needed in order to process the claim. If the claimant is not notified within the 90-day (or 180-day, if so extended) period, he or she may consider the claim to be denied.

If a claim is denied, in whole or in part, the claimant will be notified in writing of the specific reason(s) for the denial, the exact plan provision(s) on which the decision was based, what additional material or information is relevant to his or her case, and what procedure the claimant should follow to get the claim reviewed again. The claimant then has sixty (60) days to appeal the decision to the Plan Administrator.

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

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For instance, if a Participant requests materials from the Plan Administrator and does not receive them within 30 days, he/she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to \$110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

If a Participant has a claim for severance benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or federal court. If he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant has sued to pay these costs and fees. If the Participant loses, the court may order him/her to pay these costs and fees, for example, if it finds the claim is frivolous. If a Participant has any questions about the Plan, he/she should contact the Plan Administrator. Any questions about this statement or about any rights under ERISA should be directed to the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

4. Plan Document. This document shall constitute the plan document and summary plan description of the Plan.
5. Other Important Facts:

OFFICIAL NAME OF THE PLAN:	Ryder Severance Plan for Eligible Supply Chain Employees
SPONSOR:	Ryder System, Inc. 11690 NW 105 St. Miami, FL 33178 305.500.3726
EMPLOYER IDENTIFICATION NUMBER (EIN):	59-0739250
PLAN NUMBER:	529
TYPE OF PLAN:	Employee Welfare Severance Benefit Plan
END OF PLAN YEAR:	December 31 st
TYPE OF ADMINISTRATION:	Employer Administered
PLAN ADMINISTRATOR:	Chief Administrative Officer 11690 NW 105 St. Miami, Florida 33178 305.500.4743
AGENT FOR SERVICE OF LEGAL PROCESS:	Executive Vice President – General Counsel 11690 NW 105 St. Miami, Florida 33178 305.500.7797
EFFECTIVE DATE:	January 1, 2014

The Plan Administrator keeps records of the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions that an individual may have about the Plan.

Service of legal process may be made upon the Plan Administrator.

RYDER SEVERANCE PLAN FOR ELIGIBLE SUPPLY CHAIN EMPLOYEES

No individual may, in any case, become entitled to additional severance benefits or other rights under this Plan after the Plan is terminated. Under no circumstances, will any benefit under this Plan ever vest or become nonforfeitable, except as provided in Section 1 of Article VII.

Severance pay is subject to Federal and state income and Social Security tax withholdings and any other withholdings mandated by law.

For All Participants

Vacation. All Participants receive earned but unused vacation in accordance with the Company's vacation policy.

These are the only severance benefits to which a Participant is entitled except as provided in Sections 2 and 3 of Article V. No other fringe benefits, including, but not limited to, car allowances, outplacement incidentals, cell phones allowances, or other perquisites are to be paid as severance.

SCHEDULE A

SCS Plan Employees

Eligible Non-Exempt and Hourly Employees

One week Base Pay per Year of Service

Minimum: 2 weeks Base Pay

Maximum: 4 weeks Base Pay

Participants with less than one (1) Year of Service receive two (2) weeks of Base Pay.

Eligible Exempt and Salary Non-Exempt Employees

MS 01-07, SN01-06, SA 10, 63, 64, 65, 66, 67, 72, 75, 77, IT 30-31 and AA01-02

One week Base Salary per Year of Service

Minimum: 2 weeks Base Pay

Maximum: 4 weeks Base Pay

Participants with less than one (1) Year of Service receive two (2) weeks of Base Salary.

EXHIBIT 12

MIN – Set 014

PPO – Set 052

PS1 – Sets 033, 035, 040, 041, 066, 067, 113-120, 128, 129, 130, 131, 136 -141

PP1 – Sets 088, 089, 132 – 135, 142 -147



HEALTHCARE BENEFITS HANDBOOK:
DELTA ACCOUNT-BASED HEALTHCARE PLAN
(Other Than PPO Option B, PPO Option B Out-Of-Area,
FDMO Options, Dental Option B and FDMO Dental Option)

FOR ACTIVE, INACTIVE, COBRA AND
CERTAIN RETIREE AND SURVIVOR PARTICIPANTS

Summary Plan Descriptions (SPD)
Effective as of January 1, 2019

WINNING TOGETHER
FOR YOUR HEALTH

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INTRODUCTION

Your health and well-being are important to the Company. We want you to succeed both on the job and in your personal life. To do so, you need to take care of yourself. That is why the Company offers you the opportunity to enroll in many types of healthcare benefits.

The Company's healthcare plans enable you to choose the type and level of coverage that are right for you and your family. Therefore, you may choose to enroll yourself, along with your Spouse and/or your children — or you may choose to waive coverage.

This handbook applies to ground, flight attendant, flight dispatcher, pilot, Delta Vacations, LLC (Delta Vacations), Delta Material Services, LLC (DMS) and Delta Flight Products, LLC (DFP) employees, as well as certain Delta, DMS and DFP retirees and survivors that are eligible for the Delta-Account Based Health Care Plan. Effective January 1, 2016, employees of Delta subsidiary Delta Material Services, LLC (DMS) became eligible to participate in the options described in this handbook under the Delta Account Based Health Care Plan. Effective January 1, 2017, employees of Delta subsidiary Delta Flight Products, LLC (DFP) became eligible to participate in the options described in this handbook under the Delta Account Based Health Care Plan.

For purposes of this handbook, the term "Company" will be used when referring to both Delta and subsidiaries of Delta Vacations, DMS and DFP.

This handbook does not apply to those employees, retirees or survivors described in the callout box below.

This handbook does not apply to pre-merger Northwest (PMNW) employees who went on inactive payroll status, including disability status, prior to the date their respective represented workgroup transitioned to Delta pay and benefits and who have not yet returned to active payroll status; eligible PMNW flight attendant, ground and flight dispatcher employees who retired after January 1, 2010 and prior to the date their respective represented workgroup transitioned to Delta pay and benefits; and eligible survivors of these employees or retirees. Further, it does not apply to PMNW pilots who were inactive or disabled on the collective bargaining agreement implementation date (CBAID), October 30, 2008, and have not yet returned to active status or have retired since CBAID without returning to active status, as well survivors of such pilots or retirees who have died since CBAID. Employees, retirees and survivors in these groups should refer to the *Healthcare Benefits Handbook* specific to these groups for information on their healthcare benefits.

This handbook does not contain the description of the Delta Account-Based Healthcare Plan Flight Dispatchers Medical Option (FDMO) or the FDMO Dental Options. Active/inactive flight dispatchers or their survivors should refer to *Healthcare Benefits Handbook: Flight Dispatchers Medical Option* for information on these benefits.

HEALTHCARE BENEFITS HANDBOOK

The following chart outlines the various options described in this handbook under the Delta Account-Based Healthcare Plan in which these eligible employees, and Delta retirees and survivors may enroll. (Note that the flexible spending accounts described in this handbook do not apply to eligible retirees or survivors.) Refer to the "Eligibility" and "Enrolling for Healthcare and Flexible Spending Account Benefits" sections of this handbook for specific eligibility details about these plans and options.

Coverage	Vendor	Plan Name
Medical	UnitedHealthcare (UHC)	Delta Account-Based Healthcare Plan (DABHP) Options for Active and Inactive Employees and Their Survivors <ul style="list-style-type: none"> • Health Reimbursement Account (HRA) Medical Option • Out-of-Area (OOA) HRA Medical Option • Gold Health Savings Account (HSA) Medical Option • Silver HSA Medical Option • Bronze HSA Medical Option • OOA Gold HSA Medical Option • Puerto Rico OOA Medical Option (Puerto Rico residents only) DABHP Options for Pre-65 Retirees and Their Survivors (Until Age 65) <ul style="list-style-type: none"> • Retiree & Survivor Bronze HSA Medical Option • Retiree & Survivor Bronze OOA HSA Medical Option
	Hawaii Medical Service Association (HMSA)	Health Plan Hawaii (a medical health maintenance organization (HMO); available to those living in the HMO service area and/or based in Hawaii)
	Humana	Humana Health Plan of Puerto Rico (a medical HMO; available based on HMO service area)
Dental	Metropolitan Life Insurance Company (MetLife)	DABHP <ul style="list-style-type: none"> • Basic Dental Option • Comprehensive Dental Option
Vision	EyeMed Vision Care (EyeMed)	EyeMed Vision Care Plan
Flexible Spending Accounts <i>Healthcare Account</i> <i>Dependent Care Account</i>	UnitedHealthcare (UHC)	Delta Air Lines Medical Reimbursement Plan Delta Air Lines Pilots Medical Reimbursement Plan

Attention Flight Dispatchers and Pilots

If you are an active or inactive flight dispatcher or the survivor of a flight dispatcher who died while on active status or approved disability, additional medical and dental options are available to you under the DABHP. Please see the *Healthcare Benefits Handbook: Flight Dispatchers Medical Option* for information on these benefits.

If you are an active or retired pilot or the survivor of a pilot, an additional healthcare plan, including medical and dental coverage, is available to you. Please see the *Healthcare Benefits Handbook: Delta Pilots Medical Plan* for information on these benefits.

PLAN INFORMATION AND NOTICE

The Employee Retirement Income Security Act of 1974 as amended (ERISA) requires that certain kinds of benefit plans be described to the participants of those plans in a Summary Plan Description (SPD). This handbook constitutes the SPD for the Delta Account-Based Healthcare Plan (for options other than the FDMO medical and dental options, PPO Option B, PPO Option B Out-of-Area and Dental Option B), the Delta Air Lines Medical Reimbursement Plan and the Delta Air Lines Pilots Medical Reimbursement Plan. The SPD for the Delta Vision Plan and the medical and dental HMOs is made up of both this handbook and the summary prepared and distributed by the insurer or HMO.

This handbook is only a summary of the healthcare benefits provided by the plans named above (the "plans"). Its purpose is to give you an overview of the major features of the plans and does not cover all the terms of the plans. The provisions of the plans are defined in the official plan documents, which govern the terms and operation of the plans. The summary in this handbook does not take the place of those documents. If there is any conflict between the information in this handbook and the plan documents, the plan documents will govern.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

Updates

In addition to this handbook, you may, from time to time, be notified of the posting of updates or Summaries of Material Modifications (SMMs) that describe changes to the benefits of the plans described here. You should always timely refer to these updates, as well as the material in this handbook, to obtain the most recent information available about these benefits.

Notice of Company Rights

As with all Company benefits, Delta (or Delta Vacations, DMS or DFP in the case of their respective employees) reserves the right to amend, modify, suspend or terminate all or any part of the plans in its sole discretion at any time and for any reason. Any such amendment, modification, suspension or termination may apply to active employees, their dependents and beneficiaries, as well as former employees, inactive employees, retirees, disabled employees, employees on a leave of absence or furlough and COBRA participants, and each of their dependents. Any amendment or modification may be applied prospectively or retroactively, and may be applied only to one group of participants, such as retirees, but not to other groups of participants.

In the event that a plan is terminated, assets of the plan, if any, will first be distributed to the claims of participants and beneficiaries that have been incurred and submitted to the plan as of the termination date. However, there can be no assurance that the assets of a plan, if any, will be sufficient to fully provide benefits to such participants and beneficiaries. Any remaining assets of a plan will be disbursed to participants or beneficiaries who become eligible for benefits at a later date; however, in no event will any assets revert to the Company. The Delta Vision Plan is an insured plan and does not have plan assets to be distributed as described here.

The plans may be amended or modified by resolution of the Board of Directors or through approval or ratification by any person or persons authorized by the Board of Directors to take such actions or by

ratification by the Company through its actions as a whole with respect to such matter. The Company, the plans and their vendors have the right to recover overpayments, regardless of the cause, nature or source of the overpayments.

Nothing in any of these plans, including the receipt of benefits, is to be construed as a contract of employment, and nothing in the plan gives any employee the right to be retained in the employ of Delta, Delta Vacations, DMS or DFP or to interfere with the rights of Delta, Delta Vacations, DMS or DFP or to discharge any employee at any time.

Effective Date

This handbook summarizes the benefits available to eligible employees under the plans as of January 1, 2019, unless otherwise noted.

Obtaining a Printed Copy of This Handbook

If you would like to have a printed copy of this handbook, call the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** to learn how you can receive a printed copy. Remember, this handbook is available on Deltanet and can be printed from this site.

Other Information

If you have questions after reviewing this handbook, refer to "Where to Get More Information" section at the back of this handbook.

Patient Protection and Affordable Care Act (the Affordable Care Act) Notice of Grandfathered Status

The Delta Account-Based Healthcare Plan believes the following options under the plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act): PPO Option B and PPO Option B OOA. The Delta Air Lines, Inc. Employee Assistance Plan is also a grandfathered health plan under the Affordable Care Act.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan option may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to in writing to the Employee Service Center; P.O. Box 52045; Phoenix, AZ 85072 or by phone at **1-800 MY DELTA (1-800-693-3582)**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**.

SUMMARY OF KEY CHANGES

The list below highlights key changes made since the January 1, 2018 version of this handbook, and directs you where to go within the document for additional information:

- Effective October 1, 2018, Benefit Recovery Group manages the subrogation process for the Delta medical plans. For details on the subrogation process, see the "Coordination of Benefits; Subrogation and Right of Recovery Terms" section.
- Effective January 1, 2019, under the DABHP network options (HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA), the Medica network for Minnesota, North Dakota, South Dakota or Wisconsin has been removed. In these areas, network benefits apply if you use doctors, hospitals and other medical providers who are part of UHC's Choice Plus Network.
- Effective January 1, 2019, a special needs support program is offered at no additional cost through Delta Health Direct. This program is tailored to support Delta families of children with special needs by providing a single point of contact who can help in navigating the route of care. See "Medical Plan Programs" in the "Medical Benefits" section for details.
- Effective January 1, 2019, the target Body Mass Index (BMI) for earning 2019 Delta Health Rewards has changed from 29.9 to 27.5.
- Effective January 1, 2019, the HSA annual contribution limit has been increased to \$3,500 for employee only coverage and \$7,000 for family coverage.
- Effective January 1, 2019, in the HRA, Gold HSA, Silver HSA, Bronze HSA and Retiree & Survivor Bronze HSA Medical Options a \$250 "place of service surcharge" will apply to outpatient surgeries that are performed in a hospital. This \$250 place of service surcharge applies to Network and Non-Network Services. For more information, see the "Medical Benefits" section.
- Effective January 1, 2019, for bariatric surgery to treat morbid obesity to be covered under the medical plan, the requirement that you must have been employed by Delta and/or Northwest Airlines, Delta Vacations, DMS or DFP for a minimum of five years prior to the surgery is changed to a requirement that you must have been employed for a minimum of one year prior to the surgery. Additional eligibility requirements apply. See "What the Delta Medical Plans Cover", "Bariatric Surgery" in the "Medical Benefits" section for details.
- Effective January 1, 2018, coverage for mammograms is expanded to include ultrasounds. For details on mammogram coverage, see "What the Delta Medical Plans Cover", "Mammograms – Diagnostic or Preventive" in the "Medical Benefits" section.
- Effective April 1, 2018, the Shingrix vaccine for shingles is categorized as preventive services beginning at age 50. For details, see "What the Delta Medical Plans Cover", "Preventive Care – Routine Physicals, Women's Preventive Services, Colonoscopies, Well Child Visits" or "Shingles Vaccine" in the "Medical Benefits" section.

This list includes only the key changes made to the plan. Other changes may have also been made to this handbook that are not reflected in the above list. This January 1, 2019 version replaces the January 1, 2018 version of the *Healthcare Benefits Handbook* in its entirety, not just for the sections listed above.

ELIGIBILITY

ELIGIBILITY

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

Eligible Participants

The following groups of employees, retirees and survivors and their eligible dependents are eligible to participate in the Company benefits programs described in this handbook. However, not all of these groups may be eligible for all of the healthcare benefit options described in this handbook:

- Eligible pilot, flight attendant, ground, flight dispatcher and Delta Vacations, DMS or DFP employees on active payroll status
- Eligible pilot, flight attendant, ground, flight dispatcher and Delta Vacations, DMS or DFP employees on an inactive payroll status, including paid maternity leave or disability status
- Individuals on standard COBRA continuation coverage with open enrollment rights to options under the Delta Account-Based Healthcare Plan
- Eligible disabled pilots receiving disability benefits from the Delta Pilots Disability and Survivorship Plan who have been removed from the seniority list due to having reached 10 years on disability

Pre-Merger Delta Retirees and Survivors

- Eligible flight attendant, ground and flight dispatcher employees who retire on or after 2/1/2008 and their survivors, if under Medicare eligibility age (age 65)
- Eligible survivors of active and inactive flight attendant, ground and flight dispatcher employees who die after 2/1/2008, if under Medicare eligibility age (age 65)
- Eligible pilots who retire after 6/1/2006 and their survivors, if under Medicare eligibility age (age 65)
- Eligible survivors of pilots who were on the seniority list on or after 6/1/2006 and died while on active or disabled status, if under Medicare eligibility age (age 65)

Pre-Merger Northwest (PMNW) Retirees and Survivors

- Eligible PMNW pilots who were on active status on or after 10/30/2008 and retired after that date, and their survivors, if under Medicare eligibility age (age 65)
- Eligible survivors of PMNW pilots who were on the seniority list on 10/30/2008 and died after that date while on active or disabled status, if under Medicare eligibility age (age 65)

Attention Delta Vacations Employees

Delta Vacations does not provide access to Company-provided healthcare benefits after retirement or death. Therefore, any retiree or survivor healthcare benefits described in this handbook are not applicable to Delta Vacations employees or retirees. However, former Delta Vacations employees or survivors of Delta Vacations employees may be provided an election for COBRA continuation coverage after retirement or death, and are eligible for individual coverage through the Health Insurance Marketplace. See the "COBRA Continuation Coverage" section of this handbook for more information about COBRA rights.

540-Hour Flying Requirement for Flight Attendants

Active flight attendants are required to fly 540 hours (an average of 45 hours per month) during a designated 12-month "look-back period" to be eligible for the company-paid portion of medical and dental benefits under the Account-Based Healthcare Plan during the following "benefits year." Each look-back period begins on October 1 and runs through September 30 (October 1, 2017 to September 30, 2018 is the designated 12-month "look-back" period for the "benefits year" that begins on January 1, 2019). If you do not fly the required 540 hours during the designated 12-month period, you must pay 100% of the cost to maintain medical and dental benefits for the next "benefits year." For examples of how hours are accumulated during the "look-back" period, prorating credit hours and more general information about the 540 hours requirement, see the Annual Flying Requirement of the IFS Programs & Policies Handbook located in the IFS section of Deltanet.

Please Note: If the 540-hour flying requirement applies to you and is not met, you will be placed into the Direct Bill process and will receive a monthly invoice. You pay 100% of the cost for medical and dental benefits, as well as any other benefit-related deductions, based on your Annual Open Enrollment elections. It is important to pay your Premiums timely, as a delinquency over 90 days will result in termination of benefit coverage and cannot be reinstated until the following plan year. If you waive medical and dental benefits during Annual Open Enrollment, you will not be required to pay 100% Premium for medical and dental coverage during the calendar year. However, your hours will continue to accrue during the "look-back" period for the following calendar year.

Active Employees

You are eligible for the healthcare benefits described in this handbook if you are a regular full-time or regular part-time ground, flight attendant or flight dispatcher employee on active payroll status, or a pilot on active payroll status.

Disabled Employees

Once you are enrolled in the Company's healthcare benefits as an active employee, you may continue medical, dental, vision, Healthcare Flexible Spending Account (FSA) and, for pilots, Dependent Care FSA coverage if you are receiving paid maternity leave or disability benefits from the Delta Family-Care Disability and Survivorship Plan or the Delta Pilots Disability and Survivorship Plan (including if you are or become a 13 B. 3. Pilot as defined by the Pilot Working Agreement).

The Premium required is the same Premium required of active employees, in most instances.

If enrolled at the time you start receiving disability benefits and:

- You are a pilot, pre-tax deductions for your medical, dental and vision coverage will be deducted from your disability payments or paid maternity leave benefits. Additionally, if you are contributing to the Healthcare FSA and/or Dependent Care FSA when you begin receiving disability benefits or paid maternity leave benefits, your pre-tax contributions to your Healthcare FSA or Dependent Care FSA will continue to be deducted from your disability payments from the Delta Pilots Disability and Survivorship Plan.
- You are a regular full-time ground employee, regular part-time ground employee, flight attendant or flight dispatcher, your medical, dental, vision and Healthcare FSA coverage will be continued through pre-tax deductions from your paid maternity leave, certified time and OJI pay. If you are on short-term disability or long-term disability, your deductions are after-tax. Healthcare FSA deductions will not continue beyond the end of the calendar year during which your disability began. Once on inactive status, including disability, your eligibility for the Dependent Care FSA ends.

Regular full-time ground employees, regular part-time ground employees, flight attendants and flight dispatchers who become disabled but are not receiving short-term disability benefits from the Delta Family-Care Disability and Survivorship Plan because they did not purchase such optional coverage will still be able to continue medical, dental or vision coverage, as well as Healthcare FSA participation, while on the unpaid medical leave of absence if their medical absence is certified with Sedgwick CMS. The Premium required is the same as that required of active employees. These active Premiums will be billed through the Direct Bill process. Missing deductions while on a paid leave or disability also may result in billing through the Direct Bill process. If you receive a bill, it is important that you make timely payments to avoid a coverage lapse.

If you were not enrolled in the Company's healthcare plans at the time you became disabled, you may not participate in those benefits while disabled.

If you have any questions regarding Premiums, retiring from disability or benefit availability while disabled or on medical leave of absence, please call the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)**.

Inactive Employees

Once you are enrolled in the Company's benefit plans as an active employee, you may continue certain benefits for a specified period of time if you become inactive due to an authorized leave of absence (including after a pilot reaches the maximum period of disability under the Delta Pilots Disability and Survivorship Plan for psychiatric conditions, alcoholism, and/or drug use). If you are an inactive employee on an authorized leave of absence, you may continue participating in medical and/or dental and/or vision coverage during your leave. You may not enroll in benefits coverage as an inactive employee if you did not participate while active.

If you wish to continue coverage while on a leave of absence, you are required to continue paying applicable Premiums while inactive. If you fail to pay your required Premiums, your coverage will be

HEALTHCARE BENEFITS HANDBOOK

terminated and cannot be reinstated until you return to active status. If you become inactive and are eligible to continue paying Premiums, but you are not receiving pay, you will receive information from the Employee Service Center (ESC) concerning your continued payment of Premiums.

Employees on family medical leave (FMLA), a 30-day company convenience leave, or a military leave of absence lasting for 30 days or less are required to pay the same Premiums during those leaves for medical, dental or vision benefits as apply to active employees. For employees on military leave of absence lasting more than 30 days, the type of leave you take and whether or not you are covered under a current labor agreement determine the length of time benefits may continue while on leave, and your cost for benefits while on leave.

Furloughed employees pay Premiums in accordance with the terms of their furlough program or collective bargaining agreement. Employees on a leave of absence that lasts longer than 30 days must pay the full cost for their coverage after the first 30-day period. Suspended employees are required to pay the same percentage of Premiums as active employees through the Direct Bill process for up to the first 60 days of suspension, at which time their coverage ends and a COBRA election is provided from Conduent HR Services LLC for Delta Air Lines (Conduent HR Services). The employee pays 102% of the cost of COBRA coverage.

If you have any questions about Premiums and the treatment of coverage for any inactive leaves, please call the ESC at **1-800 MY DELTA (1-800-693-3582)**.

COBRA Participants

If you leave employment with the Company or experience another qualifying event that makes you lose coverage in the healthcare plan, you may continue some healthcare coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If you were enrolled in medical, dental and/or vision coverage immediately before the loss of coverage, you may elect to continue participating in those plans. You may not enroll in benefit coverage in which you were not participating at the time of your qualifying event. For instance, if you were enrolled in medical and dental coverage, but not vision coverage, you will only be eligible to continue your medical and dental coverage through COBRA and a vision COBRA option will not be available to you.

During the next annual open enrollment period, you have the same rights as a similarly situated active employee. This means that you will be offered the same medical, dental and vision options during your COBRA open enrollment period that will be provided to active employees, but only for that type of coverage in which you were enrolled in as a COBRA participant.

You are required to pay applicable Premiums under COBRA. If you fail to timely pay your required Premiums, your COBRA coverage will terminate and cannot be reinstated.

If you are enrolled in a Healthcare FSA when you lose coverage due to a qualifying event, you also may elect COBRA in order to continue contributing (on an after-tax basis) to the FSA through the end of the calendar year in which the event occurred. Dependent Care FSA contributions cease while you are on inactive status (for pilots, other than if your contributions continue while receiving disability benefits or paid maternity leave benefits from the Delta Pilots Disability and Survivorship Plan) and are not eligible for COBRA coverage.

See the "COBRA Continuation Coverage" section of this handbook for more information about COBRA rights.

Retirees

Delta offers retiree health coverage under the plans described in this handbook, based on the following criteria. Retiree health coverage eligibility under the plans described in this handbook ends upon reaching Medicare eligibility age (age 65):

- If you are a regular full-time ground employee, regular part-time ground employee, flight dispatcher or flight attendant **hired before January 1, 2010**, you are eligible for retiree health coverage if you retire after completing at least one year of service and are at least age 52 **or** have completed 25 years of service* regardless of age
- If you are a regular full-time ground employee, regular part-time ground employee, flight dispatcher or flight attendant **hired on or after January 1, 2010**, you are eligible for retiree health coverage if you retire after completing at least 10 years of service and are at least age 52 **or** have completed 25 years of service* regardless of age
- If you are a pilot employee (other than a pre-merger Northwest pilot), you are eligible for retiree health coverage when you retire
- If you are a pre-merger Northwest pilot who was active on or after October 30, 2008, and **retired after that date**, you are eligible for retiree health coverage
- If you are a pre-merger Northwest pilot who was inactive or disabled on October 30, 2008, and you return to active status thereafter and then retire, you are eligible for retiree health coverage when you retire

Note: If you are a pilot employee, including a pre-merger Northwest pilot, who retired on or before January 1, 2013 or are the survivor of such a pilot retiree, retire after January 1, 2013 as part of the Pilot Retiree Medical Account (RMA) Program or are the survivor of such a pilot retiree, or are the survivor of a pilot who died before January 1, 2013 from active or disabled status, you remain eligible to enroll in the DPMP OOA Medical Option upon reaching Medicare eligibility age (age 65). For more information, see the Healthcare Benefits Handbook: Delta Pilots Medical Plan

For more details about retiree benefits, see the "Thinking About Retirement" section of this handbook. The Spouse and children of a retiree also are eligible for healthcare benefits if they meet the eligibility requirements of the plan, as outlined in "Eligible Dependents," later in this "Eligibility" section.

Attention Delta Vacations Employees

Delta Vacations does not provide access to Company-provided healthcare benefits after retirement. Therefore any retiree healthcare benefits described in this handbook are not applicable to Delta Vacations retirees. However, former Delta Vacations employees may be provided an election for COBRA continuation coverage after retirement, and are eligible for individual coverage through the Health Insurance Marketplace. See the "COBRA Continuation Coverage" section of this handbook for more information about COBRA rights.

* Former Delta employees who went to work immediately for DMS or DFP and were given the designation of founders by DMS or DFP are granted their continuous years of Delta service from their most recent date of hire for purposes of this requirement.

HEALTHCARE BENEFITS HANDBOOK

Survivors

Eligibility for survivor medical, dental and vision benefits and the duration of those benefits are based on the deceased employee's or retiree's circumstances as well as the deceased's relationship to the survivor.

If you are a regular full-time ground, regular part-time ground, flight attendant or flight dispatcher employee or retiree at the time of your death, your eligible survivors, who meet the criteria under "Eligible Dependents," are:

- Your Spouse under Medicare eligibility age (age 65)
- Your natural born or legally adopted children who meet the criteria under "Eligible Dependents" later in this section

Non-dependent children, domestic partners and parents who may be eligible for travel benefits are ineligible for survivor healthcare benefits.

Eligibility for Ground and Flight Attendant Survivor Healthcare Benefits When Employee Is Enrolled in a DABHP Option at the Time of Death		
Criteria for Eligibility	Healthcare Benefits for Eligible Spouses*	Healthcare Benefits for Eligible Dependent Children**
<ul style="list-style-type: none"> • The deceased full-time regular ground, part-time regular ground, flight attendant or flight dispatcher employee had 10 or more years of service from the most recent hire date <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • The full-time regular ground, part-time regular ground, flight attendant or flight dispatcher employee died while active or while on approved disability <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • The full-time regular ground, part-time regular ground, flight attendant or flight dispatcher retiree died while on standard early retirement (was at least age 52 at retirement) 	Generally available until he or she reaches Medicare eligibility age (age 65), regardless of whether the Spouse remarries	Generally available through the end of the month in which they turn 26 years old
The deceased full-time regular ground, part-time regular ground, flight attendant or flight dispatcher employee had fewer than 10 years of service from the most recent hire date, and the employee died while active or while on approved disability	Available for up to 10 years following the employee's death (or, if earlier, until the surviving Spouse reaches Medicare eligibility age (age 65)), regardless of whether the surviving Spouse remarries	Available until the earlier of: <ul style="list-style-type: none"> • Ten years following the employee's death • The end of the month in which they turn 26 years old

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Eligibility for Ground and Flight Attendant Survivor Healthcare Benefits When Employee Is Enrolled in a DABHP Option at the Time of Death		
Criteria for Eligibility	Healthcare Benefits for Eligible Spouses*	Healthcare Benefits for Eligible Dependent Children**
The deceased full-time regular ground, part-time regular ground, flight attendant or flight dispatcher retiree had fewer than 10 years of service from the most recent hire date and was at least age 52 at retirement	Available for up to 10 years following the retiree's death (or, if earlier, until the surviving Spouse reaches Medicare eligibility age (age 65)), regardless of whether the surviving Spouse remarries	Available until the earlier of: <ul style="list-style-type: none"> • Ten years following the retiree's death • The end of the month in which they turn 26 years old
The deceased full-time regular ground, part-time regular ground, flight attendant or flight dispatcher retired before age 52	No survivor healthcare benefits are available following the retiree's death	No survivor healthcare benefits are available following the retiree's death

*The employee's/retiree's spouse who meets the criteria under "Eligible Dependents," which appears later in this "Eligibility" section.

**The employee's/retiree's legally adopted or natural born dependent children who meet the criteria under "Eligible Dependents," which appears later in this "Eligibility" section.

If you are a Delta pilot, on active payroll status at the time of your death, or were on the seniority list on or after October 30, 2008 and (i) are receiving disability benefits from the Delta Pilots Disability and Survivorship Plan (not the NWA LTD Plan) at the time of your death; or (ii) were on active status on or after October 30, 2008, and retired after that date, your Spouse and children who meet the following eligibility requirements (in addition to the eligibility requirements outlined under "Eligible Dependents" later in this "Eligibility" section of the handbook) are eligible for survivor medical, dental and vision coverage under the plans described in this handbook:

- Your Spouse at the time of the Delta pilot's death, but not a Spouse whom the pilot married while disabled or while not actively at work (unless the pilot returned to active work after such marriage was established), and
- Your natural born or legally adopted children who meet the criteria under "Eligible Dependents" later in this section.

Please Note: If you were married for less than one year and/or adopted a child less than one year before the last day you worked, your survivor may be asked to show evidence that you were in good health at some time between the date of the marriage/legal adoption and the date you last worked.

Same-Sex Domestic Partners of Employees or Retirees Who Died Before January 1, 2018

Prior to January 1, 2018, the plans described in this Handbook extended survivor healthcare benefit eligibility to eligible same-sex domestic partners. Effective January 1, 2018, same-sex domestic partners who qualified for these benefits prior to that date will retain such eligibility subject to the other terms and conditions of the applicable plans.

Attention Delta Vacations Employees

Delta Vacations does not provide access to Company-provided healthcare benefits after the death of an employee or retiree. Therefore any survivor healthcare benefits described in this handbook are not applicable to Delta Vacations employees or retirees. However, when a Delta Vacations employee or retiree dies, a COBRA continuation coverage election may be extended to dependents who were covered under the plan at that time. See the "COBRA Continuation Coverage" section of this handbook for more information about COBRA rights. These dependents are also eligible for individual coverage through the Health Insurance Marketplace.

Eligible Dependents

Medical, dental and vision benefits also are available to the eligible dependents of employees and eligible retirees.

The Company complies with the Patient Protection and Affordable Care Act (also known as "healthcare reform") with respect to the plans described in this handbook. This legislation overrides the plan's normal eligibility standards involving children. However, the plan's eligibility rules remain in place and continue to apply if your child does not meet the eligibility requirements under current healthcare reform legislation. Note also that Delta is voluntarily extending the same healthcare reform child eligibility rules to dental and vision coverage even though this is not required by the law.

If you are a retiree, note that, unless a HIPAA new dependent special enrollment event applies and you notify the ESC within 60 days of that event, new dependents acquired after retirement will not be eligible for medical, dental and vision coverage. See the "Life Events" section of this handbook for information about the HIPAA new dependent special enrollment event and the requirements that must be followed by the retiree.

Your eligible dependents are:

- Your Spouse
- Your eligible children (**as defined by healthcare reform**)
 - Natural born or legally adopted children through the end of the month in which they turn 26 years old. For a legally adopted child to be covered, the legal adoption must have occurred before the child turned 18 years old
 - Stepchildren through the end of the month in which they turn 26 years old
 - Children through the end of the month in which they turn 26 years old and for whom you have been appointed legal guardian by a court prior to the child's 18th birthday
 - Foster children through the end of the month in which they turn 26 years old

As stated above, the plans' eligibility rules have not been eliminated. As a result, a plan provision may make a child eligible, when the healthcare reform provisions would not. This could apply in the case of a child who is incapable of self-support, an eligible grandchild or an alternate recipient under a Qualified Medical Child Support Order (QMCSO) who have been approved by the Plan Administrator.

- Your eligible children (**as defined by the medical plan**):
 - Natural born or legally adopted children up to age 19 (adopted prior to the child's 18th birthday) if they:
 - > Have never been married (no exemption for annulments)
 - > Are not employed full-time
 - > Reside permanently in your household (except for time spent away at school or while away on a qualified missionary service), or
 - > Reside outside your household, and you provide more than 50% support
 - Natural born or legally adopted children age 19 to 23 (adopted prior to the child's 18th birthday) if they:
 - > Are full-time students or involved in qualified missionary service (see "Young Adults" later in this section for details)
 - > Have never been married (no exemption for annulments)
 - > Reside permanently in your household (except for time spent away at school or while away on a qualified missionary service), or
 - > Reside outside your household, and you provide more than 50% support
 - Stepchildren who have lived in your household for 30 full and continuous days (other than time spent living at school) if they meet the other criteria for natural born and legally adopted children
 - Children, regardless of age, who are incapable of self-support due to mental or physical handicaps if the handicap occurred before meeting the plan's maximum age limit (age 26) and the child meets and maintains all other requirements applicable to children under 19 (not married, not employed full-time, etc.). Incapacitation approval by the claims administrator is required before reaching the age 26 limit
 - Children for whom the employee or retiree has been appointed legal guardian by a court before the children turned 18 years old, who meet the other criteria for natural born and legally adopted children, and who live permanently in the employee's home (other than time spent living at school)
 - Foster children who live with you in a parent-child relationship and are primarily dependent on you for support
 - Grandchildren, as long as their mother or father is eligible for and covered by the plan(s) as your dependent child, the mother or father lives in your home with the grandchildren and the grandchildren are primarily dependent on you for support
 - Children who are alternate recipients under a Qualified Medical Child Support Order (QMCSO) who have been approved by the Plan Administrator

Qualified Medical Child Support Orders (QMCSOs)

The plans maintain written procedures governing the intake and approval of QMCSOs. You have the right to receive, without charge, a copy of the QMCSO procedures. You may request a copy of these procedures by contacting the ESC at **1-800 MY DELTA (1-800-693-3582)**.

Attention Employees Married to Another Employee

Employees, retirees and survivors and their dependents (Spouses and eligible children) are only permitted to be enrolled once in the Delta Account-Based Healthcare Plan or the Delta Pilots Medical Plan, regardless of marital status or relationship to other Delta employees (or retirees).

Medical/Dental/Vision Coverage

If both you and your Spouse or child are eligible for the Delta Account-Based Healthcare Plan, you cannot be covered under the Plan as both an employee, retiree or survivor (a "primary plan member") and a dependent of another primary plan member. Your coverage options are:

- ✦ Be covered individually as the primary plan member only, or
- ✦ Be covered as the primary plan member with your Spouse or eligible child covered as your dependent (or vice versa)

In the event you and your Spouse (or ex-Spouse) have children eligible for medical coverage only one parent (or step parent) may cover the child as a dependent. If your child is a primary plan member, the child may not also be enrolled as a dependent on a retiree's, survivor's or employee's coverage.

Young Adults

The following provides additional details regarding eligibility if your dependent is a full-time student or in missionary service.

Full-Time Students

Your dependent must meet the following eligibility criteria to be considered a full-time student:

Institution of study

- Your dependent must attend high school full-time at a school with a regular teaching staff, course of study and a regularly enrolled body of students in attendance. This does not include home schooling or
- Your dependent must attend, in person or via online courses, an accredited university, United States Armed Forces Service Academy (U.S. Military, Naval, Air Force, Coast Guard or Merchant Marines Academies), or college that offers graduate and/or undergraduate courses toward a degree program and is accredited by an accreditation agency recognized by the United States Department of Education. A foreign university or college is acceptable if it meets its country's accreditation requirements. The college or university can be on a semester, quarter or 4-1-4 system*; or
- Your dependent must attend, in person, a vocational/technical school accredited by a nationally recognized accreditation agency recognized by the Department of Education

* 4-1-4 students attend fall and spring term and a one-month term during January. Each credit at 4-1-4 school system is equivalent to four semester hours or six quarter hours. Students normally enroll in four courses for the fall and spring terms, and can take up to 2.25 courses during the summer.

Type of study

- Your dependent may be enrolled in a traditional course of study
- Your dependent may be enrolled in a full-time work/study program accredited as a Cooperative Education Program (Co-op), provided that the program is full-time and offered through a college or university that meets the "Institution of study" requirements listed above
- Your dependent may participate in a full-time internship program under which undergraduate and graduate students receive credits that apply toward their degrees
- Your dependent is not considered a full-time student if he or she is enrolled in correspondence courses
- Your dependent is not considered a full-time student if he or she is enrolled in online courses on less than a full-time basis and/or if the institution offering these online courses does not meet the requirements of "Institution of study," listed earlier

Required course load/attendance requirements

- Your dependent must enroll in and complete a minimum of two-thirds of the school's required hours/credits to be considered a full-time student (under the school's requirements, based on records in the registrar's office)
- If your dependent attends a school that offers year-round classes, the child is entitled to take one quarter or semester off each calendar year (based on whether the school has quarters or semesters) without losing his or her status as a full-time student. However, if the school does not offer classes year-round, your dependent may only take off the summer session without losing his or her full-time student status. Note that your dependent cannot take off two consecutive quarters/semesters without losing his or her eligibility under the plans
- Your dependent also may be employed full-time as long as he or she meets all of the requirements for full-time student status during the time that he or she is employed

Approved time off from classes

- If your dependent stops his or her studies in the middle of a quarter/semester, then he or she is eligible under the plans as a full-time student for the remainder of that quarter/semester. However, that quarter/semester counts as your dependent's one free quarter/semester for the calendar year
- If, on your dependent's 19th birthday, he or she is not attending school full-time, he or she remains a full-time student under the plan during a 90-day grace period
- If your dependent graduates from high school or a college/university and is scheduled to attend a college/university or graduate degree program in the fall semester or quarter, he or she is allowed to take off the length of the summer session for the institution he or she plans to attend, even if that period is longer than 90 days
- If the child follows a 4-1-4 calendar system, he or she may take one semester/quarter off each calendar year

Documenting full-time student status

If you are required to submit verification of full-time student status to the ESC, you must provide at least two of the following acceptable forms of documentation:

- Your most recent tax return noting full-time student status, or
- 1098-T Form, or
- Paid tuition receipt for the current semester that displays the name of the educational institution, or
- Most recent report card that displays the name of the educational institution, or
- Most recent transcript that displays the name of the educational institution

as well as

- Registration indicating student status or number of credit hours for the current semester, or
- Class schedule for the current semester

Michelle's Law

Michelle's Law extends eligibility for group health benefit plan coverage to certain dependents between age 18 and the plan's maximum age that are enrolled in coverage at the time that they take a medically necessary leave of absence from a post-secondary educational institution due to a serious illness or injury. Specifically, the law extends eligibility to those enrolled dependent children who have been full-time students at the time of an illness, but would lose coverage when a medically necessary leave of absence causes the child to fall below the course load required for full-time student status. This extension of eligibility is available for up to one year.

You must notify the Employee Service Center (ESC) and request an extension of eligibility for your dependent within 60 days of the illness or injury that was the cause for the medically necessary leave of absence.

Missionary Service

Missionary service is defined as voluntary, unpaid, full-time work devoted to a ministry (preaching, education or medical work) commissioned by a church or other religious organization for the purpose of propagating its faith or carrying on humanitarian work. "Unpaid" means that the individual in missionary service does not directly or indirectly receive any salary, pay allowance, expenses or other remuneration or compensation while, or on account of, performing the service. It is intended that an individual who is in qualified missionary service be primarily dependent on the employee for support while in such service.

If you are required to submit verification of missionary service to the ESC, you must provide a letter of missionary service that is satisfactory to the plan(s) and that is prepared and certified by the church or religious organization for which the missionary service is performed.

The letter must contain:

- A detailed description of:
 - The missionary service performed by your dependent
 - The purpose of such missionary work
 - The name of the church or other religious organization for which such missionary service is performed
- The time period that your dependent is committed to perform such missionary service. Note that the plan only covers your qualified dependent for up to 24 months of missionary service
- The place (city/state/country) where the missionary service is performed
- Descriptions of any room, board, allowance, expenses, etc. that are to be paid to or on account of your dependent while in such missionary service
- A description of the church/religious organization for which the missionary service is performed and its purpose
- A statement indicating that the missionary service is voluntary

Initial Certification of Continued Eligibility (as Defined by the Medical Plan) on Dependent's 19th Birthday

You will be sent an email notification 45 days in advance of your dependent turning age 19 (for example, if your child's 19th birthday is February 15, the email will be sent January 1). If you are not able to certify that your dependent is a full-time student or in missionary service, and your student does not meet the healthcare reform eligibility rules, your dependent's eligibility will end at the 90th day after his or her 19th birthday and, if eligible, a COBRA continuation election will be extended to him or her. Even if your student isn't required to prove full-time student eligibility for continued healthcare coverage due to healthcare reform, do not ignore this certification as it may be required to retain dependent travel privileges.

Continued Verification of Dependent's Eligibility

From time to time, you may receive a "Full-time Student/Qualified Missionary Service Verification" notice from the ESC advising you to verify your dependent's full-time student/missionary service status. If you are not able to verify that your dependent continues to be a full-time student or in missionary service — or you do not complete the verification process by the verification deadline — your dependent's eligibility for the plan will end on the coverage expiration date noted in your verification notice. In addition, COBRA continuation coverage will not be extended to your dependent.

The coverage cancellation date may be:

- The last date that full-time student/qualified missionary service verification was completed, or
- The date that your dependent was last verified as a full-time student, or
- The date that your dependent last completed a qualified missionary service

If, at any time, your child no longer meets the full-time student or missionary service qualifications, it is your responsibility to report the dependent's loss of eligibility through Self Service. See the "Life Events" section of this handbook for more details on loss of eligibility and how to report it. If you do not report this loss of eligibility in a timely manner, or if you falsify any eligibility verification information, this may result in collection of overpaid benefits and possible disciplinary action, up to and including your termination of employment or benefits.

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Dependent Documentation Requirements

To add new dependents to your health benefits, you must first access the **My Dependents** page from **Self Service** on Deltanet. (See the "Life Events" section of this handbook for more information about when you may add a new dependent.) Once dependents are added, you may enroll them for coverage (if eligible) in the Benefits Direct tool on Deltanet.

A random audit may be performed of those individuals who reported a life event change online during the same time frame that you did. If you are chosen to be audited, you will be required to provide documentation to substantiate your dependent's eligibility. If you are not able to provide this documentation, the documentation is not acceptable, or you do not complete the request and respond in a timely manner, your dependent's eligibility for the plan may be cancelled retroactive to the date your dependent was recently added to coverage through Benefits Direct. COBRA continuation coverage will **not** be offered for failure to respond timely or completely to the audit request.

The timely reporting of some life event changes will continue to require you to complete a Family Status Change Form that you must submit to the ESC, along with proper documentation of eligibility. See the "Life Events" section of this handbook for a list of the types of new dependent qualifying events that require completion of the form.

Acceptable forms of proof are outlined in the following chart, as well as in the My Dependents page from Self Service on Deltanet (which is where you add your dependent). If your child qualifies under the standard eligibility rules of the plan (for example, as a full-time student), you may be asked for additional documents, as noted in the following chart.

2019 Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	Acceptable Documentation
Spouse	<ul style="list-style-type: none"> • A marriage certificate showing the names of you and your Spouse • If your marriage did not occur in the current calendar year, a copy of the first page of your tax return from the prior year, or an alternate document demonstrating financial interdependence (such as joint bank account, mortgage, lease, credit cards)
Child (Natural Born)	<ul style="list-style-type: none"> • A birth certificate showing you as the parent • A Social Security card for this dependent (for a newborn, you may not have this card yet) <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying residency (first page of most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing that the employee has full custody of child)

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2019 Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	Acceptable Documentation
Child (Natural Born, Out of House)	<ul style="list-style-type: none"> • A birth certificate showing you as the parent • A Social Security card for this dependent (for a newborn, you may not have this card yet) <p>If child does not fall under the health care reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying financial support, including one of the following: acceptable divorce decree, custody agreement or court order showing the name of the child and the level of support the employee provides — or proof of a pattern of support in the form of cancelled checks for a recent six-month period • If you claim this child as a dependent on your tax return, proof that you are the non-custodial parent claiming the child as a dependent (your most recent tax return, including Form 8332)
Child (Natural Born, Student)	<ul style="list-style-type: none"> • A birth certificate showing you as the parent • A Social Security card for this dependent <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying residency (first page of your most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing that the employee has full custody of the child) • Documents which display the name of the educational institution or church/religious organization (if on missionary service), the name of the dependent, and the time period of education or missionary service • For students, at least two documents which confirm status, credit hours and time period of enrollment, such as most recent tax return noting full-time student status, 1098-T form, paid tuition receipt, report card, transcript AND registration or class schedule. For missionary service – a letter from the religious organization with description of the service, time period and expenses

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2019 Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	Acceptable Documentation
Child (Natural Born Student, Out of House)	<ul style="list-style-type: none"> • A birth certificate showing you as the parent • A Social Security Card for this dependent <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying financial support including one of the following: acceptable divorce decree, custody agreement or court order showing the name of the child and the level of support the employee provides — or proof of a pattern of support in the form of cancelled checks for a recent six-month period • If you claim this child as a dependent on your tax return, proof that you are the non-custodial parent claiming the child as a dependent (your most recent tax return, including Form 8332) • Documents which display the name of the educational institution or church/religious organization (if on missionary service), the name of the dependent, and the time period of education or missionary service • For students, at least two documents which confirm status, credit hours and time period of enrollment, such as most recent tax return noting full-time student status, 1098-T form, paid tuition receipt, report card, transcript AND registration or class schedule. For missionary service — a letter from the religious organization with description of the service, time period and expenses
Child (Step)	<ul style="list-style-type: none"> • A birth certificate or adoption order showing your Spouse as the parent • A Social Security card for this dependent (for a newborn, you may not have this card yet) <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying residency (first page of your most recent tax return, or if you or your Spouse are not claiming the child on a tax return, the divorce decree or court order showing that your Spouse, who is the parent of the child, has full custody of the child)
Child (Step, Student)	<ul style="list-style-type: none"> • A birth certificate or adoption order showing your Spouse as the parent • A Social Security card for this dependent <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying residency (first page of your most recent tax return, or if you or your Spouse are not claiming the child on a tax return, the divorce decree or court order showing that your Spouse, who is the parent of the child, has full custody of the child) • Documents which display the name of the educational institution or church/religious organization (if on missionary service), the name of the dependent, and the time period of education or missionary service • For students, at least two documents which confirm status, credit hours and time period of enrollment, such as most recent tax return noting full-time student status, 1098-T form, paid tuition receipt, report card, transcript AND registration or class schedule. For missionary service — a letter from the religious organization with description of the service, time period and expenses

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2019 Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	Acceptable Documentation
Child (Adopted)	<ul style="list-style-type: none"> • An adoption placement order, a petition to adopt, or an adoption finalization order dated prior to the child's 18th birthday • A Social Security card for this dependent <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying residency (first page of your most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing that the employee has full custody of the child)
Child (Adopted, Out of House)	<ul style="list-style-type: none"> • An adoption placement order, a petition to adopt or an adoption finalization order dated prior to the child's 18th birthday • A Social Security card for this dependent <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying financial support (one of the following: acceptable divorce decree, custody agreement or court order showing the name of the child and the level of support that the employee provides — or proof of a pattern of support in the form of cancelled checks for a recent six-month period) • If you claim this child as a dependent on your tax return, you have and will retain proof that you are the non-custodial parent claiming the child as a dependent. (Your most recent tax return including form 8332)
Child (Adopted, Student)	<ul style="list-style-type: none"> • An adoption placement order, a petition to adopt or an adoption finalization order dated prior to the child's 18th birthday • A Social Security card for this dependent <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying residency (first page of your most recent tax return, or if divorced and not claiming the child on your tax return, the divorce decree or court order showing that the employee has full custody of the child) • Documents which display the name of the educational institution or church/religious organization (if on missionary service), the name of the dependent, and the time period of education or missionary service • For students, at least two documents which confirm status, credit hours and time period of enrollment, such as most recent tax return noting full-time student status, 1098-T form, paid tuition receipt, report card, transcript AND registration or class schedule. For missionary service – a letter from the religious organization with description of the service, time period and expenses

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2019 Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	Acceptable Documentation
Child (Adopted, Student, Out of House)	<ul style="list-style-type: none"> • An adoption placement order, a petition to adopt or an adoption finalization order dated prior to the child's 18th birthday • A Social Security card for this dependent <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Documentation verifying financial support (one of the following: acceptable divorce decree, custody agreement or court order showing the name of the child and the level of support that the employee provides — or proof of a pattern of support in the form of cancelled checks for a recent six-month period) • If you claim this child as a dependent on your tax return, you have and will retain proof that you are the non-custodial parent claiming the child as a dependent. (Your most recent tax return including form 8332) • For students, at least two documents which confirm status, credit hours and time period of enrollment, such as most recent tax return noting full-time student status, 1098-T form, paid tuition receipt, report card, transcript AND registration or class schedule. For missionary service — a letter from the religious organization with description of the service, time period and expenses
Foster Children	<ul style="list-style-type: none"> • Legal documentation showing the child has been placed in your home as a foster child <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Proof of residency
Foster Children - Student	<ul style="list-style-type: none"> • Legal documentation showing the child has been placed in your home as a foster child <p>If child does not fall under the healthcare reform eligibility rules the following is also required:</p> <ul style="list-style-type: none"> • Proof of residency • Documents which display the name of the educational institution or church/religious organization (if on missionary service), the name of the dependent, and the time period of education or missionary service. • At least two documents which confirm status, credit hours and time period of enrollment, such as a most recent Tax Return noting full-time student status, 1098-T form, paid tuition receipt, report card, transcript AND registration or class schedule. For missionary service — a letter from the religious organization with description of service, time period and expenses
Child Legal Guardian	<ul style="list-style-type: none"> • Birth certificate of the dependent • Social Security card for this dependent • Documentation showing the employee has legal guardianship with signatures and court seal/stamp naming the employee as the child's legal guardian prior to the child's 18th birthday • Documentation verifying residency (first page of your most recent tax return)

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2019 Acceptable Proof of Eligibility for Certain Covered Dependents	
Dependent	Acceptable Documentation
Child Legal Guardian - Student	<ul style="list-style-type: none"> • Birth certificate of the dependent • Social Security card for this dependent • Documentation showing the employee has legal guardianship with signatures and court seal/stamp naming the employee as the child's legal guardian prior to the child's 18th birthday • Documentation verifying residency (first page of your most recent tax return) • Documents which display the name of the educational institution or church/religious organization (if on missionary service), the name of the dependent, and the time period of education or missionary service • For students, at least two documents which confirm status, credit hours and time period of enrollment, such as most recent tax return noting full-time student status, 1098-T form, paid tuition receipt, report card, transcript AND registration or class schedule. For missionary service – a letter from the religious organization with description of the service, time period and expenses
Grandchildren	<ul style="list-style-type: none"> • A birth certificate showing your covered dependent daughter or son as the parent • Hospital record showing the child's parent(s) • Paternity test showing the child(s) parent • Court child support order that shows the child's parents • State Affidavit of Parentage or Paternity (or like form) that acknowledges the paternity of the child. This form must have some indication that it was filed with the state or with the court • A Social Security Card for this dependent (for a newborn you may not have this card yet) • Documentation verifying residency (first page of your most recent tax return)

For more information about proving dependent eligibility, you may contact the ESC at **1-800 MY DELTA (1-800-693-3582)**, Monday – Friday 8 a.m.-5 p.m., Eastern time. You also can access Benefits Direct through Employee Connection, 24 hours a day, seven days a week.

Who Is Not Eligible

The following employees are not eligible to enroll themselves or their dependents in DABHP healthcare benefits described in this handbook:

- Leased employees
- Seasonal employees
- Contract employees
- Ready Reserve employees
- Part-time Customer Experience Specialist – Work@Home employees
- Flight attendant trainees
- International employees
- Employees of certain subsidiaries or affiliates that have not adopted the DABHP

When Coverage Begins

When your coverage begins depends on whether or not you are covered under a labor agreement and whether you are an existing employee, a new employee, an employee returning to active payroll status, a retiree or survivor.

Existing Active Employees Enrolling Annually

The benefit elections that you make during Annual Open Enrollment go into effect for you and your eligible dependents on January 1 of the following year.

What Happens to Your Annual Open Enrollment Elections?

If, while you were on active status, you made healthcare benefit elections during the annual open enrollment period (typically in October or November), but were on inactive status the following January 1 (the date Annual Open Enrollment elections normally become effective), generally, those elections will go into effect on January 1 and become your default coverage when you return to active status, at which time you will be given the opportunity to make new benefit elections.

For example:

- ◆ John was on active status during the annual open enrollment period — October 30, 2018 through November 16, 2018 — and made his benefit elections for the 2019 plan year. However, on December 1, 2018, John went out on short-term disability and did not return to work until February 1, 2019.
- ◆ Following his return to work in February 2019, John was given a new enrollment period to make benefit elections for 2019.
- ◆ If John does not make any elections during his designated enrollment period, his healthcare coverage will default to what he had elected during the annual open enrollment period.

New Employees

Your benefit elections become effective on the earlier of the 1st or the 16th day of the month following 30 days of employment for ground and flight dispatcher employees, or the earlier of the 1st or the 16th of the month following 45 days of employment for flight attendants, unless your employment with the Company as a flight attendant, ground or flight dispatcher employee is terminated or you move to an ineligible employment status before then. For pilots, coverage is effective on your date of employment.

Inactive Employees Returning to Active Payroll Status

If you are on inactive status and return to active payroll status, your benefit enrollment process will depend on the year in which you return to work.

Returning During the Same Calendar Year (Before The Annual Open Enrollment Period)

You will not receive a separate enrollment opportunity to change your coverage upon your return. Your coverage is reinstated into the plans you and your eligible family members were enrolled in prior to your leave, regardless of whether or not you continued your coverage while inactive.

Returning During the Same Calendar Year (After The Annual Open Enrollment Period)

You will be given a two-week extension on your Annual Open Enrollment event to make healthcare elections for the new plan year as an active participant. These elections go into effect for you and your eligible dependents on January 1 of the following year, if you are on active status.

Returning During a Different Calendar Year

You will be mailed an enrollment notification directing you to enroll online by using Benefits Direct.

Any changes you make to your coverage during the designated enrollment period become effective on the 1st or 16th of the month following the end of the designated enrollment period, if you are on active status.

If you do not elect coverage during your enrollment window, coverage will default to the healthcare elections you made during the prior annual open enrollment period. If you did not make elections during the prior annual open enrollment period, your coverage will default to what you were enrolled in prior to your leave. This excludes enrollment in a Healthcare or Dependent Care FSA, or a per pay period HSA deduction election, as you must actively elect such coverage.

Rehired Employees/Employees Moving To a Benefits Eligible Status

Benefits for ground, flight dispatcher or flight attendant employees who are rehired within the same calendar year are effective on the date of rehire. Those rehired in a different plan year will see their benefits effective on the earlier of the 1st or the 16th of the month, following 30 days of re-employment.

If you are a rehired pilot, your benefit coverage is effective your date of rehire, whether your rehire date is in the same calendar year or a different calendar year.

The above rules for pilots as well as ground, flight dispatcher and flight attendant employees also apply to anyone moving into a benefits eligible status. For example, if you are in a ready reserve position and change to a full-time regular position, your benefit elections are effective on the earlier of the 1st or the 16th of the month, following 30 days as a full-time regular employee (benefits eligible status).

Retirees

Upon retirement, eligible employees have the option of electing 18 months of COBRA coverage, a Delta retiree medical and/or dental option or waiving coverage.

If you elect Delta retiree coverage, your coverage is retroactive to the first day of the month following your last day of employment once you complete your retiree 30-day enrollment period.

If you are eligible for and elect COBRA, your coverage is retroactive to the first day of the month following your last day of employment once you have completed the COBRA enrollment application and made payment of your currently due Premiums to the COBRA administrator, Conduent HR Services LLC for Delta Air Lines (Conduent HR Services).

When your COBRA coverage period ends (typically, at the end of 18 months), you may immediately enroll in a Delta retiree medical option without having to wait for the annual open enrollment period. This means that, as long as your COBRA Premiums are timely paid and you follow the proper enrollment procedures in a timely manner (for instance, you notify the ESC within 30 days of the end of your COBRA coverage), you should not have any lapse in coverage.

Survivors

Upon the death of the employee or retiree, eligible survivors are given an opportunity to change their benefit elections and must do so within 30 days of the death. Benefits will default to "No Coverage" if elections are not made during this time. Survivor coverage begins for all eligible dependents on the date of the employee's or retiree's death.

When Coverage Ends

For You

Your coverage for medical (including prescription drug), dental, vision and Healthcare FSA benefits ends on the earliest of the following dates:

- The earlier of the 15th or the last day of the month in which your last day of employment occurs (If you are retiring, your active coverage terminates at the end of the month in which you were last employed)
- The earlier of the 15th or the last day of the month in which you are in an employment status eligible for benefits (this can occur when your employment status changes and you become part of a job class that is not eligible for benefits or is eligible for a different plan)
- The first day of the month in which a retiree or survivor reaches Medicare eligibility age (age 65), if you are a retiree or survivor (or the first day of the previous month if your birthday is on the first of the month). Note: If you are a pilot who retired on or before January 1, 2013 or the survivor of such a pilot retiree, a pilot who retires after January 1, 2013 as part of the Pilot RMA Program or the survivor of such a pilot retiree, or the survivor of a pilot who died before January 1, 2013 from active or disabled status, you remain eligible to enroll in the DPMP OOA Medical Option upon reaching Medicare eligibility age (age 65). For more information, see the *Healthcare Benefits Handbook: Delta Pilots Medical Plan*
- The earlier of the 15th or the last day of the month (last day of the month, if you pay monthly Premiums) in which the employee dies or the last day of the month in which a survivor or retiree dies (review the survivor eligibility information that appears earlier in this "Eligibility" section to determine the eligibility of family members following a retiree's death)
- The first day of the month for which you fail to pay required Premiums by the specified due date
- No later than sixty days after you are placed on disciplinary suspension (for pilots, disciplinary suspension without pay)
- The day you are suspended pending termination
- Fifteen days after you are denied short-term or long-term disability benefits (unless denied disability and still receiving worker's compensation benefits, in which case benefits end immediately)
- The day you fail to return to work after an approved absence (including FMLA) during which your coverage is extended. You may have to pay the full cost for coverage you received during an FMLA leave if you terminate from the Company at the end of the leave without returning to work
- After six months on personal leave of absence (applies only to ground/flight attendant employees)
- The start of a plan year in which you have selected the "No Coverage" option
- The end of any period of continued coverage provided under a continuation provision of the Delta healthcare plans or due to law
- The day the plan is terminated

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If the loss of coverage event listed above is a COBRA qualifying event, you will be sent a COBRA election package after your coverage terminates that enables you to elect to continue your coverage for up to 18 months (through the end of the calendar year for the Healthcare FSA). Note that Premium amounts required to maintain coverage may increase when you move from one employment status to another (such as moving from active employee to employee on personal leave), even though you do not become ineligible at that point.

Dependent Care Flexible Spending account eligibility ends when you leave active pay status (for pilots, for any reason other than disability), terminate or retire. You are not able to extend coverage of your Dependent Care FSA after your coverage ends.

For Your Dependents

For your dependents, medical, dental and vision coverage ends on the earliest of the following:

- The day the employee's or retiree's coverage ends (Note: If the retiree's coverage ends due to reaching Medicare eligibility age (age 65), the dependent's coverage may continue as long as the dependent continues to meet the eligibility requirements)
- The earlier of the 15th or the last day of the month (last day of the month, if you pay monthly Premiums) in which you voluntarily drop coverage for your dependent due to a qualified life event change
- The start of a plan year in which you elect not to cover a dependent
- The day your dependent dies (only coverage for that dependent ends)
- The first day of the month in which a retiree's dependent reaches Medicare eligibility age (age 65) (or the first day of the previous month if your dependent's birthday is on the first of the month)
- The earlier of the 15th or the last day of the month (last day of the month, if you pay monthly Premiums) following your death (review the survivor information that appears earlier in this "Eligibility" section for information about coverage for dependents following the employee's or retiree's death)
- The first day of the month for which you fail to pay any required Premiums for your dependent's coverage
- The end of the period for which you could not or did not provide proof that your dependent met the eligibility requirements
- The effective date of any amendment causing your dependent to lose eligibility for coverage
- The day the plan is terminated
- The date of your final decree of divorce
- Through the last day of the month in which your dependent child becomes ineligible due to reaching age 26
- Through the earlier of the 15th or the last day of the month or, if you pay monthly Premiums, through the last day of the month in which:
 - Your dependent child marries (not applicable if healthcare reform rules apply)
 - Your dependent child becomes ineligible due to reaching age 19, or, if a full-time student, reaching age 23 (not applicable if health care reform rules apply)
 - Your dependent child becomes ineligible following qualified missionary status (not applicable if healthcare reform rules apply)

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- Your dependent child becomes employed full-time (not applicable if healthcare reform rules apply)
- Your dependent child moves permanently out of your household and you no longer provide 50% or more support for the out-of-house child (not applicable if healthcare reform rules apply)
- In the case of stepchildren, you are no longer married to the child's parent
- Your dependent child loses full-time student eligibility (and healthcare reform provisions do not apply). Note: When a full-time student loses eligibility through graduation, coverage ends the earlier of the 1st or the 16th of the month (or if you pay monthly Premiums, the first day of the month) following 90 days after graduation. If a student turns 26 while a full-time student, healthcare coverage ends the last day of the month in which they turn 26 years old
- Any other dependent eligibility requirement is not met

For more information about when coverage begins or ends for you and your eligible dependents, you may contact the ESC at **1-800 MY DELTA (1-800-693-3582)**, Monday – Friday 8 a.m.-5 p.m., Eastern time. You also can access Benefits Direct through Self Service, 24 hours a day, seven days a week.

Coverages End Due to Non-Payment of Premium

If you are an inactive employee or retiree/survivor, your coverage ends — and you are no longer eligible to enroll in the Company's healthcare benefits — if you do not pay your Premiums on time. Your healthcare coverage ends if you are more than 90 days late with benefit Premiums (payments are due on the first day of the month for that month's coverage). Additionally, coverage will end for any voluntary coverages (for example, Optional and/or Dependent Life Insurance, Group Accident and/or Family Group Accident Insurance, or Private Pilots Accident Insurance) for which you may have been paying premiums.

You might miss paying a Premium for a variety of reasons, such as:

- You did not mail a Premium payment (if you pay via Direct Bill)
- Your account cannot cover your Premium payment for reasons such as insufficient funds, stop payment orders, bad account information, errors written on a check, and closing of the account
- Your Direct Debit Authorization Form (if you have submitted one to the ESC) has errors that prevent your direct debit arrangement from being processed, or you did not submit a cancelled check
- You sent your Premiums to the wrong address. The correct address is:
 Conduent HR Services LLC for Delta Air Lines
 P.O. Box 382119
 Pittsburgh, PA 15251-8119

If You Do Not Pay Your Premiums or Pay Late

- If full payment is not received within 60 days of the payment due date, a \$25 late fee is added to your account and is reflected on your next invoice
- If you are a direct debit participant, your payment method may be switched to Direct Bill if the Company is unable to process a deduction for your benefits coverage. A debit failure may occur for many reasons, including incorrect account information, insufficient funds or a closed account. If your debit is rejected because of insufficient funds, a \$25 fee is charged to your account. After you have sent a check for the full amount owed, you may re-elect the direct debit payment method via Benefits Direct or by contacting the ESC to request a new Direct Debit Authorization Form
- If full payment is not received within 90 days of the payment due date, your benefit coverage is terminated retroactively to the end of the last month for which full payment was received. Once coverage is terminated for late or missing payments, your coverage cannot be reinstated, and you become responsible for the cost of any claims incurred as of the coverage termination date. Any Premium payments received after your coverage is terminated will be returned to you
- You are not eligible for COBRA continuation coverage

Future Enrollment Rights

If your coverage is terminated for nonpayment and you are:

- *A retiree or survivor*, you become excluded from future enrollment opportunities and unable to reenroll for lost coverage under any circumstances
- *An inactive employee*, you become excluded from future enrollment opportunities and unable to reenroll for lost coverage until you return to active employment status with the Company or, if you are a Delta employee, retire from inactive status (if you are eligible for coverage in retirement). If you die, your survivors may be eligible for medical and dental coverage. (For details, see the survivor information at the beginning of this section)

Requesting a Review of Your Coverage Termination

You or a representative designated in writing by you may request that the Administrative Subcommittee of the Delta Account-Based Healthcare Plan review your medical and/or dental coverage termination. Direct your written request to:

Secretary, Administrative Subcommittee/Delta Account-Based Healthcare Plan
Delta Air Lines, Inc.
Department 844
P.O. Box 20706
Atlanta, GA 30320-6001

ENROLLING FOR HEALTHCARE AND FLEXIBLE SPENDING ACCOUNT BENEFITS

ENROLLING FOR HEALTHCARE AND FLEXIBLE SPENDING ACCOUNT BENEFITS

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

When to Enroll

A newly eligible employee (newly hired or those hired from a Delta position that was not benefits-eligible) or rehired eligible employee is given the opportunity to enroll in healthcare coverage and Flexible Spending Accounts (FSAs) soon after his or her hire or rehire date. After you are hired, an Enrollment Notification will be mailed to your home address informing you of your enrollment deadline and guiding you to Benefits Direct, where you can view your benefit options and make your elections. You should read the information in this notification carefully.

In addition, an annual open enrollment period for healthcare benefits, and in some cases, FSAs, is extended to active and inactive employees or their survivors, retirees or their survivors (except Delta Vacations), and COBRA participants, as described in this section.

Ground, Flight Attendant, Flight Dispatcher, Delta Vacations, DMS and DFP New Hires

If you are an eligible ground, flight attendant or flight dispatcher new hire or newly eligible employee, including employees of Delta Vacations, DMS or DFP, you must enroll for your medical, dental, vision and FSA benefits during your first 27 days of employment. You may enroll your Spouse and eligible dependents as well. If you miss this enrollment opportunity, you and your dependents will not have medical, dental or vision coverage, and you must wait, generally, until the next annual open enrollment period to enroll for these benefits, unless you have a qualified life event that allows you to enroll mid-year (see the "Life Events" section of this handbook for details).

Your benefit elections become effective:

- *For ground, flight dispatcher, Delta Vacations, DMS and DFP employees:* On the earlier of the 1st or the 16th day of the month following 30 days of employment, unless your employment with Delta is terminated or you move to an ineligible employment status before then.
- *For flight attendants:* On the earlier of the 1st or the 16th day of the month following 45 days of employment, unless your employment with Delta is terminated or you move to an ineligible employment status before then.

You may not change your elections during the year unless you experience a qualified life event change. See the "Life Events" section in this handbook for information about the types of benefit elections that may be modified as a result of various life event changes.

Pilot New Hires

As a newly hired pilot, medical and dental coverage begins on your employment date. From your employment date until the date your enrollment elections take effect, your coverage automatically consists of:

- Medical — Gold HSA Medical Option
- Dental — Comprehensive Dental Option
- Flexible Spending Accounts — No coverage
- Vision — No coverage

This coverage requires you to pay a Premium that is deducted from your paycheck. See the Benefits Direct enrollment site for the actual Premium amounts required per pay period.

During your new hire enrollment period, you may enroll in benefits for yourself and for your Spouse and eligible children. The benefit elections that you make during your enrollment period for you and your eligible dependents will be retroactive to your date of hire (including during your interim period). Once your enrollment period has expired and your benefit elections go into effect, your Premiums are deducted on a pre-tax basis while you are on active payroll status or, if elected, from disability benefits from the Delta Pilots Disability and Survivorship Plan if you become disabled.

If you do not enroll by the enrollment election deadline, the coverage shown above becomes your permanent election for the remainder of the year. This is called your “default coverage.” Unless you have a qualified life event, you cannot elect to cover your Spouse and eligible dependents until the next annual open enrollment period.

Rehires

If you are rehired by the company after having terminated employment with Delta (including rehired retirees), you are eligible to enroll for medical, dental, vision and FSAs as an active employee. Any retiree coverage you had in effect before your rehire will cease when you are re-employed.

Employees Rehired in a Year Other Than the Year They Terminated Employment

For benefit coverage for yourself and your eligible dependents, you must enroll within 27 days of your rehire date. Coverage is effective on the earlier of the 1st or the 16th day of the month following 30 days of employment. Automatic coverage for pilots becomes effective on your rehire date.

Employees Rehired the Same Year They Had Terminated Employment

On your rehire date, the benefits that you were enrolled in before your termination automatically become effective for you and the dependents you previously covered (assuming they remain eligible). No action on your part is necessary.

Annual Open Enrollment

Each fall, an annual open enrollment period is held for eligible participants. The benefit decisions you make during Annual Open Enrollment are effective during the following plan year (from January 1 to December 31). You may not change your elections during the year unless you have a qualified life event change. See the "Life Events" section in this handbook for more details.

Different enrollment rules may apply, depending on your employment status.

Active Employees

All eligible active employees have the option to enroll or change benefit elections during the annual open enrollment period conducted each fall, in accordance with plan rules.

Elections that you make during Annual Open Enrollment as an active employee become effective the following January 1, only if you continue to be on the Delta payroll and are actively at work on the day your benefits are to become effective.

What Happens to Your Annual Open Enrollment Elections?

If, while you were on active status, you made healthcare benefit elections during the annual open enrollment period (typically in October or November), but were on inactive status the following January 1 (the date Annual Open Enrollment elections normally become effective), generally, those elections will go into effect on January 1 and become your default coverage when you return to active status, at which time you will be given the opportunity to make new benefit elections.

For example:

- ◆ John was on active status during the annual open enrollment period — October 30, 2018 through November 16, 2018 — and made his benefit elections for the 2019 plan year. However, on December 1, 2018, John went out on short-term disability and did not return to work until February 1, 2019.
- ◆ Following his return to work in February 2019, John was given a new enrollment period to make benefit elections for 2019.
- ◆ If John does not make any elections during his designated enrollment period, his healthcare coverage will default to what he had elected during the annual open enrollment period.

Inactive Employees

If you are on inactive status during an annual open enrollment period, please read this section carefully. Inactive employees currently enrolled in healthcare coverage may participate in Annual Open Enrollment for healthcare coverage only. Additionally, inactive pilots receiving disability benefits from the Delta Pilots Disability and Survivorship Plan also can make Flexible Spending Account (FSA) elections during Annual Open Enrollment.

If you choose the "No Coverage" option for medical, dental and/or vision coverage while on inactive status (for instance, while on disability or leave of absence), there are certain consequences. You cannot reinstate coverage until you return to active payroll status unless you or your dependent(s) experience a qualified life event change known as a Health Insurance Portability and Accountability Act (HIPAA) special enrollment event (for medical and dental coverage only). However, if you retire or die while on inactive status and are eligible for medical/dental benefits, you or your survivors will be given an opportunity to enroll in Delta healthcare coverage at the time of your retirement or death (for survivors). Also, if you elect "No Coverage" and you lose other coverage as a result of a HIPAA-qualifying event, you may reinstate Delta medical, dental or vision coverage if you report the event within 60 days. See the "Life Events" section of this handbook for more information about HIPAA special enrollment events and how to report life event changes.

If you are on inactive status and return to active status, your benefit enrollment process will depend on the year in which you return to work.

- If you return to work in the same calendar year and before the annual open enrollment period, you will not receive a separate enrollment opportunity to change your coverage upon your return.
- If you return to work in the same calendar year, but after the annual open enrollment period, you will be given a two-week extension on your Annual Open Enrollment event to make healthcare elections for the new plan year as an active participant.
- If you return to work in the next, or a later, calendar year, you will be mailed an enrollment notification directing you to enroll online by using Benefits Direct. Any changes you make to your coverage during the designated enrollment period become effective on the 1st or 16th of the month following the end of the designated enrollment period, if you are on active status. If you do not elect coverage during your enrollment window, coverage will default to the elections you made during the prior annual open enrollment period. If you did not make healthcare elections during the prior annual open enrollment period, your coverage will default to what you were enrolled in prior to your leave. This excludes enrollment in a Healthcare or Dependent Care FSA or a per pay period HSA deduction election, as you must actively elect such coverage.

Delta Retirees/Survivors

Delta retirees and survivors may enroll themselves in medical, dental and vision coverage until they reach Medicare eligibility age. A retiree's dependents may also be enrolled in medical, dental and vision coverage until the dependent reaches Medicare eligibility age.

If you are a pilot retiree or survivor, you also have the option of coverage under the Delta Pilots Medical Plan (DPMP) until you reach the Medicare eligibility age. After reaching the Medicare eligibility age, medical coverage under the DPMP, as well as vision coverage, is available only to certain, eligible pilot retirees and survivors. For information on the DPMP and eligibility after reaching the Medicare eligibility age, see the *Healthcare Benefits Handbook: Delta Pilots Medical Plan*.

Please Note: Retirees of Delta Vacations are not eligible for retiree health coverage under the plans described in this handbook or otherwise.

COBRA Participants

COBRA participants may be eligible for the DABHP, as noted in their Annual Open Enrollment materials. If you are a COBRA participant and you waive COBRA coverage during an enrollment, your COBRA coverage cannot be reinstated in the future.

If you leave Delta employment or experience another qualifying event (see the "COBRA Continuation Coverage" section of this handbook for more information), you may be eligible to continue medical, dental and/or vision coverage for up to 18 or 36 months under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Through COBRA, you also may continue to contribute to a Healthcare FSA through the end of the calendar year in which your event occurred.

While enrolled in COBRA coverage, you have the same enrollment rights as a similarly situated active employee, as noted in your Annual Open Enrollment materials. If you are a COBRA participant and you waive COBRA coverage during an open enrollment period, your COBRA coverage cannot be reinstated in the future.

You are required to continue paying applicable Premiums on a timely basis. If you fail to pay your required Premiums on a timely basis, your COBRA coverage will terminate and cannot be reinstated.

Other Events Requiring Re-Enrollment/Enrollment

Some events can trigger a mid-year enrollment opportunity for you. After the following events occur, you must re-enroll in healthcare coverages:

- You move from an employment status in which you are not eligible for benefits to an employment status in which you are benefits eligible
- You return from a leave of absence, layoff or furlough during a different calendar year from the one in which your absence began. Note, you are not required to re-enroll in healthcare coverages if you made healthcare elections during the prior annual open enrollment period while you were inactive. Those elections will be your default coverage, and you will be given an enrollment opportunity when you return if you wish to change your coverage elections.

How to Enroll

All active employees must complete their benefits enrollment online through Benefits Direct. Inactive employees, eligible retirees and survivors should also, when at all possible, enroll via the online enrollment tool.

If you have questions about online enrollment, or if you experience difficulty enrolling, contact the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** before the enrollment deadline. International callers should dial **404-677-8000**.

Step 1: Enroll Online Via Benefits Direct

Go online to **<https://deltanet.delta.com>**. You can use any computer with Internet access. You will need a valid Delta Passport password. (If you can access TravelNet or if you have home access to Deltanet, you have a valid Passport password.)

- Go to **<https://deltanet.delta.com>** and enter your 9-digit employee number (Username), along with your Delta Passport password
- From the Deltanet home page, click on **Self Service**
- From the **Self Service** home page, click on **Benefits Direct**

Benefits Direct allows you to review your current coverage and dependents that are on file, and make your elections.

Note: Before you make elections that involve your dependents, review and maintain your dependent information. From the **Self Service** home page, click on **My Dependents** to view, maintain or add dependent information. You may also submit a Family Status Change Form with the Employee Service Center (ESC). Contact the ESC at **1-800 MY DELTA (1-800-693-3582)** for assistance.

It is your responsibility to maintain complete and accurate dependent data with Delta. Your failure to do so may result in the denial of eligibility and possible repayment of claims costs.

Step 2: Review Your Options

Details about your benefit options, coverage levels and plan costs are available on Benefits Direct. To view benefits brochures and other plan information in Benefits Direct, click on "Library" on the home page.

Be sure to review the online Enrollment Worksheet to see the coverage you will receive if you don't make any elections during your enrollment period. Default coverage may require you to pay Premiums (Employee Contributions), so review your options carefully.

Alex®

ALEX®, the interactive tool that you can consider your personal benefits counselor, asks you a series of questions including questions about your expected healthcare usage to offer help in the benefits election process. Based on your responses to the questions, ALEX® makes plan option suggestions to you at the end. ALEX® explains your benefits and helps you understand what options might make the most sense for you and your family.

Active and inactive employees can access ALEX® from the Benefits Direct home page. To get to Benefits Direct, follow the instructions in Step 1, earlier in this section.

Health Plan Evaluator

The Health Plan Evaluator can help you review your medical benefit options. This interactive online tool enables you to identify coverage features, out-of-pocket costs and other factors that are important to you. If you are currently enrolled in a Delta health plan administered by UnitedHealthcare, your claims information from a recent 12-month period automatically appears in the tool. Unlike ALEX®, the Health Plan Evaluator uses your actual claims, if you had any during that 12-month reporting period, but it doesn't make a plan suggestion to you like ALEX® does.

With this tool, you can:

- Compare your medical options side-by-side
- Use your claims history to help estimate your medical expenses
- Revise your estimated claims costs by accounting for any anticipated healthcare needs or change in health status
- Calculate your cost of the Eligible Expenses that can be reimbursed by an FSA or HSA

Active and inactive employees can access the Health Plan Evaluator and other benefit estimators via Benefits Direct by clicking on "Health, Disability & Insurances", then "Tools & Resources". To get to Benefits Direct, follow the instructions described in Step 1, earlier in this section.

Also in this area of Benefits Direct under "Tools & Resources", then "Helpful Links", you can find links to vendor websites, making it easy to learn if your doctor or provider is in the plan's network, for example. Remember, using Network Providers typically saves you money.

Step 3: Update Your Elections

Once you have determined which benefits are available and best meet your needs, make your elections. You must make your elections by the deadline communicated to you. If you do not make changes during your enrollment period, you are automatically enrolled in the default coverage shown on Benefits Direct.

You will not have another opportunity to change your elections until the next annual open enrollment period, unless you experience a qualified life event change.

If you are currently enrolled but wish to decline coverage, you must actively enroll in the "No Coverage" option.

Step 4: Submit Elections

After you have updated your elections, click "Submit Changes" to ensure that any changes you have made are received. **If you do not see a message confirming that your elections have been saved, your changes will not be effective.**

Step 5: Confirm, Revise If Needed

Be sure to print the online confirmation page so you have a record of the elections you have made.

If you want to change those elections before the end of the enrollment period, go back to the enrollment area of Benefits Direct and make new elections. When you are done, click "Submit Changes" and reprint your confirmation page. Remember, when you make a change, you should print your confirmation page so you have a record of your elections.

Enrollment Problems?

If you need help getting to the benefits enrollment site or have questions about enrollment, contact the ESC at **1-800 MY DELTA (1-800-693-3582)** for assistance. International callers should dial **404-677-8000**.

If You Do Not Enroll

Be sure you understand what happens if you do not enroll for benefits or if you enroll in the “No Coverage” option. Also refer to “Waiving Coverage” later in this section of the handbook.

During Annual Open Enrollment

If you are enrolled in Delta benefits and you do not make any benefit elections during Annual Open Enrollment, most of your current benefit elections will continue in effect for the following plan year. You are assigned the coverage in effect at the end of the previous year, provided that particular benefit plan is still offered. There are three exceptions:

- Flexible Spending Accounts (FSAs). If you do not actively elect to contribute to an FSA, your default contribution is \$0
- Health Savings Accounts (HSAs) contributions. If you do not actively elect to contribute to an HSA, your default contribution is \$0
- Discontinued benefit options. If you are in a Delta benefit option that is no longer being offered, you must actively enroll in an alternative election during Annual Open Enrollment or you receive default coverage. The specifics of the default coverage are explained to you on Benefits Direct. Be certain the default coverage meets your needs before deciding not to actively enroll

Also, note that default coverage may require Premium contributions. If you wish to decline coverage and avoid incurring such costs, you must actively enroll in the “No Coverage” option during the annual open enrollment period.

As a New Hire

New hires who do not actively enroll during their new hire enrollment period receive the following default coverage:

- Medical — Ground, flight attendant, flight dispatcher, Delta Vacations, DMS and DFP employees default to “No Coverage;” pilots default to the Gold HSA Medical Option
- Dental — Ground, flight attendant, flight dispatcher, Delta Vacations, DMS and DFP employees default to “No Coverage;” pilots default to the Comprehensive Dental Option
- Vision — No coverage
- Healthcare FSA — No coverage
- Dependent Care FSA — No coverage

Will Default Coverage Meet Your Needs?

Make sure you understand the coverage you are electing or defaulting into. If you choose not to enroll for benefits, make sure the default coverage meets your needs. You can view your default coverage on your Benefits Direct worksheet. There, you can see the coverage you will receive if you do not make any elections during the enrollment period.

Remember that after your enrollment period ends, you can only change your benefits during the year if you have a qualified life event change. See the “Life Events” section of this handbook for details.

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Waiving Coverage

You have the option of selecting the “No Coverage” medical, dental and/or vision option. If you waive medical, dental and/or vision coverage during the annual open enrollment period, it is important to understand the following.

If You Are Eligible As ...	And You Choose the “No Coverage” Option ...
An active employee	You waive medical, dental and/or vision coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot obtain coverage for the calendar year unless: <ul style="list-style-type: none"> • You or your dependent experience certain special enrollment events (see the “Life Events” section of this handbook) • You retire from Delta and qualify for retiree healthcare benefits, or • You die and your survivors are eligible for survivor healthcare benefits (see the “Eligibility” section of this handbook)
An active employee who becomes disabled or inactive An inactive or disabled employee	You cannot enroll in medical, dental and/or vision coverage until you return to active pay status unless you or your dependent experience an eligible special enrollment event (see the “Life Events” section of this handbook)
An active employee who retires during the year	You may enroll for medical, dental and/or vision coverage at the time of your retirement and during future annual retiree open enrollment periods if you qualify for retiree healthcare benefits upon retirement (see the “Eligibility” section of this handbook)
An active, inactive or retired employee, and you die	Your eligible survivors may enroll for coverage at the time of your death and during future annual open enrollment periods as long as they remain eligible (see the “Eligibility” section of this handbook for survivor healthcare eligibility rules)
A retired participant	You waive medical, dental and/or vision coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot obtain coverage for the calendar year unless you or your dependent experience certain special enrollment events (see the “Life Events” section of this handbook) or you die and your survivors are eligible for survivor healthcare benefits (see the “Eligibility” section of this handbook for survivor healthcare eligibility rules)
A survivor eligible for Delta healthcare benefits	You waive medical, dental and/or vision coverage for the entire year
A COBRA participant	You waive your right to elect Delta medical, dental and/or vision coverage forever

Changing Your Coverage During the Year

After you initially enroll in benefits, if you remain an active employee, you may not make changes to your benefit elections or changes to the dependents you have covered until each fall's annual open enrollment period (with elections effective the following January 1), unless you have a qualified life event, such as marriage or the birth of a child. See the "Life Events" section of this handbook for more details.

If you have declined enrollment and elected the "No Coverage" option for yourself or your dependents (including your Spouse) because of other health insurance coverage, and that other coverage later ends, you may be able to enroll yourself or your dependents in Delta coverage. This is a Health Insurance Portability and Accountability Act (HIPAA) event, and you should report it within 60 days after your other coverage ends. See the "Life Events" section of this handbook for a definition of a HIPAA event.

In addition, if you have new dependents as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself or add your eligible dependents to coverage, provided you report the life event and make new elections within 60 days of its occurrence.

- If you are a retiree, you must be enrolled in coverage to have this special enrollment right. Moreover, as a retiree, if your request for enrollment is not received within 60 days of the marriage, birth, adoption or placement for adoption, you may never add the new dependent to coverage
- If you are an inactive pilot and you miss this 60-day reporting deadline, you cannot add the new dependent to coverage until you return to work

Note: Eligible retirees not enrolled in coverage and all eligible survivors cannot add any newly acquired dependents.

The new dependent special enrollment rights apply only to COBRA participants currently enrolled in medical coverage. If a COBRA participant waives his or her coverage, he or she relinquishes the right to COBRA continuation coverage forever for himself or herself.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) permits two additional special enrollment events. You and your dependents are eligible for a special enrollment event under CHIPRA if your or a dependent's Medicaid or state Children's Health Insurance Plan (CHIP) coverage is terminated due to loss of eligibility (but not for non-payment of premiums) or if you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. You must report the CHIPRA special enrollment event and change your election within 60 days. See the "Life Events" section of this handbook for more information.

More Information On Life Events and Changing Your Coverage

See the "Life Events" section of this handbook for more details. Or, contact the ESC at **1-800 MY DELTA (1-800-693-3582)** if you have additional questions.

How Long Elections Are Effective

Employees, retirees and survivors currently enrolled in Delta benefits — The benefit elections you make during Annual Open Enrollment become effective on January 1 of the following year and remain in effect throughout the calendar year.

Eligible new hires or those returning to work after inactive status — Your benefit elections go into effect on the earlier of the 1st or the 16th day of the month following your enrollment deadline or the event date, respectively. Your elections continue in effect the remainder of the calendar year.

COBRA participants — If you are extending your Delta coverage through COBRA, you may make your benefit elections (once you have received your COBRA enrollment package) through Conduent HR Services LLC for Delta Air Lines (Conduent HR Services), the COBRA administrator, by enrolling within 60 days on Benefits Direct or by calling the ESC. See the "COBRA Continuation Coverage" section of this handbook for more details about the amount of time that you are eligible to continue coverage through COBRA.

Log on to Benefits Direct on Deltanet (<https://deltanet.delta.com>) to review your benefits coverage.

Enrolling in an Optum Bank HSA If Also Enrolling in an HSA Medical Option

The Health Savings Account (HSA) is not an employee benefit plan sponsored or maintained by Delta. An individual who participates in an HSA Medical Option is participating in a high-deductible health plan sponsored by Delta, and accordingly, may be eligible to establish an HSA for his or her own benefit.

Delta has an arrangement with Optum Bank. Active employees who choose to set up an HSA with Optum Bank may have their HSA contributions made through pre-tax employee payroll deductions. You can also set up an HSA at another financial institution of your choosing such as the Delta Community Credit Union; however, you will be unable to contribute to that HSA through pre-tax payroll deduction.

It is important to note that the Optum Bank HSA — and any other HSA to which you contribute — is not a Delta-sponsored plan, but is instead an individual arrangement set up by you, the employee. As a participant in the HSA Medical Option, you have the choice of any HSA product you wish to use. You are not required to set up an HSA with Optum Bank or any other financial institution.

When deciding which HSA product to choose, you should consider the terms and conditions of each HSA product, including the terms relating to investment of the account, as well as the investment options available for that HSA. You also should consider the fees associated with each HSA product and investment option, as well as the terms relating to withdrawals, transfers, contributions and deposits.

If you set up an HSA with Optum Bank, you may make contributions through pre-tax payroll deductions while you are on active payroll status. You elect the pre-tax payroll deduction amount for your Optum Bank HSA account (up to the dollar limits) as a part of the enrollment process on Benefits Direct. However, you are responsible for monitoring the limit and participation requirements under federal law.

If you are enrolled in one of the HSA Medical Options, you must have an open Optum Bank HSA account. If you do not open an Optum Bank HSA or consent to allow your Optum Bank HSA to be opened during Annual Open Enrollment (or at other times), Delta will not be able to deposit the Delta Health Rewards that you may earn or for child funding, if eligible.

You can change your HSA contribution amount at any time during the year and are not required to fund your Optum Bank HSA through equal pay period installments throughout the year. This means that you can elect higher pay period contributions to meet your annual goal amount sooner.

If you are making payroll deductions to an Optum Bank HSA and start receiving benefits from the Delta Disability and Survivorship Plan or Delta Pilots Disability and Survivorship Plan, as applicable, special rules apply to your HSA contributions:

- Ground, flight attendant or flight dispatcher employees: If you start receiving paid maternity leave, certified time or 66.67% OJI pay, your pre-tax contributions to your Optum Bank HSA will automatically continue while receiving this type of pay. If you start receiving short-term disability (STD) benefits, your contributions to your Optum Bank HSA are automatically taken from your STD pay through the end of the calendar year on a post-tax basis because your STD benefit is not taxable
- Pilots: If you start receiving disability or paid maternity leave benefits from the Delta Pilots Disability and Survivorship Plan during the year, your pre-tax contributions to your Optum Bank HSA will automatically continue from your disability or maternity leave pay

In any other case, if you go off active pay status during the year and miss two payroll deductions, your payroll deductions automatically cease. If you wish to continue contributing to your Optum Bank HSA, you must arrange to directly deposit funds into your account. You are responsible for monitoring your applicable annual limit to make sure you do not over-contribute. Note that Delta pays the monthly account maintenance fee for the Optum Bank HSA, but other fees may apply.

If you want to start, stop or change your Optum Bank HSA account payroll deductions at other times during the year, you may do so online on Benefits Direct. See the "Life Events" section of this handbook for more information about how and where to go to change your HSA contribution amount.

For information on the Optum Bank HSA (including investment options, rules, fees and deposit instructions) and/or to set up an Optum Bank HSA, access the Optum Bank website. You are directed to this website when you complete your Delta benefits enrollment (during Annual Open Enrollment or as a new hire). You can also view the UHC pre-enrollment website prior to Annual Open Enrollment at **welcometouhc.com/delta** for information about Optum Bank HSA. When you log on, enter Username *delta* and Password *delta* (both lowercase). Once you have enrolled, you can access the Optum Bank HSA website by logging on to UHC's website at **www.myuhc.com**.

Paying for Coverage

There are three ways you can make Premium payments for your healthcare benefits: active payroll deductions, Direct Bill (if you are an inactive employee) and pension/disability deduction.

Active Payroll Deductions

If you are an active employee, your Premiums for your Delta healthcare benefits are deducted from each of your regular paychecks.

Medical and Dental Benefit Deductions for Flight Attendants Who Do Not Meet the Annual Flying Requirement

The annual flying requirement for active flight attendants is 540 hours (an average of 45 hours per month) during a designated 12-month "look-back period" to be eligible for the company-paid portion of medical and dental benefits during the following "benefits year." Please see the "Eligibility" section of this handbook for additional details on the flight attendants eligible for the annual flying requirement and the look back period.

If you do not fly the required hours during a designated 12-month period, you must pay 100% of the cost to maintain medical and dental benefits for the next "benefits year." You will be placed on the Direct Bill process (described below) to pay the cost for medical and dental benefits, as well as any other benefit-related deductions, based on your annual enrollment elections.

Direct Bill (for Inactive Employees)

If you are an inactive employee and have missed two payroll deductions, or for when no other method of payment is available (such as an active, pension or disability paycheck), you can pay your Delta healthcare Premiums through Direct Bill payments (if you have not signed up for direct debit, see below). If you are on an unpaid leave of absence, Delta healthcare Premiums must be made through Direct Bill payments. HSA contributions are not billed, but you can continue contributing to your Optum Bank HSA by directly depositing funds into your account. You are responsible for monitoring your applicable annual limit to make sure you do not over-contribute.

If you are planning to retire, note that Direct Bill is set up for retired ground, flight attendant and flight dispatcher employees who do not have enough funds in their pension and/or disability check to cover their healthcare Premiums. Retired pre-merger Delta pilots are automatically set up for Direct Bill. Direct Bill is set-up for pre-merger Northwest pilots who do not have enough funds in their pension check to cover their healthcare Premiums.

You can expect to receive your invoice around the 15th of the month. Payment is due on the first of the following month. Charges reflected on the invoice include any previous outstanding balance or credit, and the charges for the next month's Premiums.

Enrolling in Direct Debit

If you participate in Direct Bill, you may elect the direct debit payment method. You should only use direct debit if you will be on Direct Bill for 90 days or more. A period of 90 days is required because of the timing associated with processing a direct debit election and when the actual deductions occur. Also, to be eligible for direct debit, you must provide account information for a U.S. bank account.

Direct debit withdraws Premiums directly from your checking, savings, money market or credit union account, according to an established schedule.

To enroll in the direct debit payment method, log onto Benefits Direct on Deltanet. If you do not have Internet access, you can enroll by completing a Direct Debit Authorization Form. To obtain the form, contact the ESC at **1-800 MY DELTA (1-800-693-3582)**. Complete and return the Direct Debit Authorization Form to:

Employee Service Center
P.O. Box 52045
Phoenix, AZ 85072

Direct debit participants may modify their direct debit account information at any time.

Once enrolled in direct debit, you receive a statement indicating the amount that is set to be debited from your designated account. The amount debited from your bank account is always the total balance due. If your account cannot be debited for the full amount, the debit will be rejected. See "Coverages End Due to Nonpayment of Premium" in the "Eligibility" section of this handbook for details.

Pension/Disability Deduction

If you receive a pension/disability benefit from Delta, the monthly cost for healthcare coverage is deducted from your pension/disability check. Deductions occur on the first of the month for that month's coverage.

If you are a ground, flight attendant or flight dispatcher employee, pre-tax Premium deductions continue from your maternity leave, certified time and OJI pay on a pre-tax basis, or through post-tax deductions from short-term disability or long-term disability pay.

When you newly retire as a ground, flight attendant or flight dispatcher employee or as a pre-merger Northwest pilot, you are automatically set up to have Premiums deducted from your monthly pension check.

Newly retired pre-merger Delta pilots are automatically set up to pay Premiums through Direct Bill, but Premium deductions can be taken from a pre-merger Delta pilot's disability check from the Delta Pilots Disability and Survivorship Plan on a pre-tax basis.

There is an exception to this rule. If your Premium deduction amounts to 70% or more of your monthly pension/disability benefit, your Premium is not deducted from your pension/disability check. Instead, your payment method is switched to Direct Bill. You should note, however, that if you fail to make timely Premium payments through Direct Bill, your coverage will be canceled retroactive to the last date that Premiums were paid for your coverage and you will not have retiree coverage enrollment rights in future open enrollment periods. If your pension/disability check increases or your monthly Premium deductions decrease, and therefore, your pension/disability check is able to support your total monthly Premium amount, you can request to have your payment method changed back to a pension/disability check deduction – or you can elect to change your payment method to direct debit.

You always have the right to stop the deductions from your disability or retirement check for any reason by notifying the ESC. You will then be placed on Direct Bill.

You also may be eligible for COBRA continuation coverage, which you pay yourself (there are no deductions from pay or benefit checks). As with Direct Bill payments, if you fail to make timely COBRA Premium payments, your COBRA coverage will be retroactively canceled to the last date that Premiums were paid and your COBRA coverage rights will permanently terminate. Refer to the "COBRA Continuation Coverage" section in this handbook for details.

Direct Bill/Direct Debit Participants:

Report Life Event Changes Within 60 Days

If you pay your Premiums through Direct Bill or direct debit, it is very important that you report any life event changes within 60 days of the event. See the "Life Events" section of this handbook for more information on how to report life events. If such changes are not reported, ineligible dependents may continue to be covered, resulting in overpayments that you may have to repay.

If you have questions about life event changes, call the ESC at **1-800 MY DELTA (1-800-693-3582)**.

Refunds

If you cancel coverage or have overpaid, you may call the ESC to request a refund of your credit balance. You may automatically receive a Premium refund if:

- Your status changes back to active and a credit balance exists
- You die with a credit balance
- You cancel coverage and a credit balance exists

Generally, changes to your payment method are timed so that refunds are not necessary. For example, a change from Direct Bill to direct debit is effective the first month for which no payment has been received.

To ensure that refunds are not issued for funds that may be recalled by the bank (due to non-sufficient funds), Delta waits 21 days after your funds have been deposited before issuing you a refund.

Once Delta determines that you are eligible for a refund, Delta verifies that your funds were deposited at least 21 days earlier. If your deposit was made fewer than 21 days earlier, your refund is delayed until the next refund cycle.

LIFE EVENTS

LIFE EVENTS

You may find that a major life event — such as marriage or the birth of a baby — changes your benefit needs. For instance, you might want to add your Spouse or newborn to your Delta healthcare coverage.

Because of the tax advantages that apply to medical, dental, vision and flexible spending account (FSA) benefits, federal rules and regulations restrict your ability to change these benefits and change your covered dependents after your enrollment elections become effective. These rules and regulations govern the types of changes that you may make during the calendar year. In general, once you enroll in or waive coverage, your benefit elections and covered dependents stay in effect for the entire calendar year. However, under certain circumstances, you may enroll in certain coverages, add or remove covered dependents, or change certain coverages during the year.

Read this section for details on the changes you can make due to “life events” such as marriage or the birth of a baby.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the “Terms to Know” section at the end of this handbook for definitions.

When You May Change Your Medical/Dental/Vision Benefits

You may make certain changes to your medical/dental/vision elections mid-year if you experience an event that permits that change (a “**qualified life event change**”) and you report the change within 60 days of the event.

A qualified life event change includes the following events:

- Adding or losing a Spouse due to marriage, divorce, annulment or death
 - Note:** If you are a retiree who has reached the Medicare eligibility age (age 65) and marry someone under the Medicare eligibility age (age 65), your newly acquired Spouse is ineligible for healthcare benefits as you are not enrolled in these medical, dental, and/or vision plans.
- Adding or losing a dependent child due to marriage, birth, adoption or placement for adoption, gaining or losing custody, permanent legal guardianship, Qualified Medical Child Support Order (QMCSO), divorce or death
- Any change that results in a dependent losing his or her dependent status, such as reaching the maximum age for coverage or, in the case of a stepchild, your divorce from the stepchild’s parent
- Any change that results in a dependent gaining his or her dependent status under the plans
- Changes in your eligible dependent’s employment status in which your eligible dependent gains or loses eligibility for benefits in his or her employer’s plan(s). This includes if your eligible dependent begins or returns from an unpaid leave of absence; quits; changes employers; is laid off or fired; if there is a significant increase in the cost of your eligible dependent’s coverage; if there is a significant reduction in the coverage provided under your eligible dependent’s employer’s plan; or if your Spouse adds you to, or drops you from, his/her coverage during your Spouse’s employer’s annual open enrollment period

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- Changes to correspond with a change made under another employer plan during that plan's annual open enrollment period if the other employer plan has a different plan year
- Changes because your or a dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility (not for non-payment of premiums) or if you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP
- Changes because you or a dependent enrolled in or dropped Medicare coverage
- Dropping coverage for you and your dependents due to enrollment in a qualified health plan offered through a state or federally facilitated exchange but only if (i) you and your dependents are eligible to enroll in the qualified health plan during an exchange special enrollment or annual enrollment period AND (ii) the new exchange coverage is effective no later than the day immediately following the last day of the Delta coverage.

TRICARE and Age 60

If you are an active, inactive or retired ground, flight attendant, flight dispatcher or pilot employee who is eligible for TRICARE coverage (federal health benefits for military retirees), upon turning age 60 and if you provide documentation showing you have enrolled in TRICARE coverage, you may drop your Delta medical coverage and, if you choose, enroll in the TRICARE Supplement Plan. Eligible employees will only be allowed to drop Delta medical coverage and, if you are active, enroll in the optional TRICARE Supplement Plan; changes cannot be made to your dental, vision or Healthcare/Dependent Care FSA elections due to this status change. This change must be requested within 60 days of your 60th birthday.

Please send a signed and written request along with proof of Tricare coverage to the Employee Service Center (ESC) to make updates to your medical coverage. Your medical coverage change will be effective the 1st or the 16th of the month following the date the ESC receives the written request to drop your Delta medical coverage. Contact the ESC at **1-800 MY DELTA (1-800-693-3582)** if you have questions.

Any change you make to your medical, dental and vision elections must be consistent with the type of event you experience. For example, assume you are single when you first enroll, and you elect medical and dental coverage for yourself only. If you later get married, you can add your new Spouse (and any eligible stepchildren) to your healthcare coverages within 60 days, but you cannot enroll in a different medical option. If you have questions about what types of medical, dental and vision benefit election changes are consistent with various qualified life events, contact the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)**.

Note that any amounts accumulated toward your annual Deductible and Out-of-Pocket Maximum will be maintained if you change medical coverage tiers following a qualified life event. For example, if you are enrolled in the Gold HSA Medical Option prior to your qualified life event and you change to family coverage after the birth of an eligible dependent child, the claim amounts already used to build-up your year-to-date Deductible and Out-of-Pocket Maximum will not reset to zero. Claim amounts will continue to accumulate toward the Deductible and Out-of-Pocket Maximum through the end of that calendar year or until you cease medical coverage.

Report Your Change Within 60 Days

All qualified life events must be reported within **60 days** of the occurrence for your requested benefit elections/changes to be considered valid. All participants (active, inactive, retirees, survivors and disabled employees, as well as COBRA participants) have a 60-day deadline.

See "How to Report a Life Event" later in this "Life Events" section of the handbook to learn the various ways that you may report your qualified life events and make applicable changes to your benefits.

Contact the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** if you have questions about reporting qualified life events.

When You May Change Your FSA Elections

If you have a qualifying life event change, you may be eligible to make changes to your Healthcare or Dependent Care FSA election during the year. You must report the qualifying life event within 60 days of the occurrence to be eligible to make any allowed changes to your FSA contributions.

Depending on the qualifying life event, you may be able to enroll, stop participating, increase or decrease your contributions. Any change you make must be consistent with the type of qualified life event you experience. For detailed information about FSA changes you can make for various life events, contact the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)**.

If you stop your contributions to one or both of the FSAs because of a qualified life event (this means you stop participating in the FSA), you still can file claims for Eligible Expenses incurred before your participation stopped and contributions ended.

Even If You Are Not Changing Benefits ... Report All Life Event Changes

You must report life event changes even if you do not want to change your benefit elections, or even if you are not enrolled in Delta benefits coverage. You should do this because your life event change might affect other Delta benefits, such as pass privileges for you or your dependents.

HIPAA Special Enrollment Rights

The following information and rules are required by federal law under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you waive Delta medical or dental coverage, generally you, your Spouse, and/or dependent children can re-enroll during the year if you become eligible for a "HIPAA special enrollment."

You and/or your dependent(s) are eligible for a HIPAA special enrollment under the following circumstances.

Loss of Other Health Coverage

If you, your Spouse or dependent were eligible but declined enrollment in Delta medical and/or dental coverage previously (when initially eligible, at Annual Open Enrollment or when a qualified life event change occurred) because of other medical or dental coverage, and employer contributions toward the other medical or dental coverage end — or you and your dependents lose eligibility for the other coverage due to any of the following reasons:

- Divorce or legal separation
- Death
- The plan is changed so that you, your Spouse or your dependent are no longer eligible
- Termination of employment
- Reduction in hours

Note: Loss of coverage due to nonpayment of Premiums, voluntarily discontinuing that coverage or fraud does not trigger a special enrollment event. Also, special enrollment rights do not apply to vision coverage.

The special enrollment rights last for 60 days only; therefore, you must enroll within 60 days after your or your dependents' other medical or dental coverage ends (or after the employer stops contributing toward the other medical or dental coverage).

Exhaustion of COBRA Continuation Coverage

If you or a dependent are enrolled in medical or dental COBRA continuation coverage under another group health plan when you decline coverage under the Delta plan, you and/or your dependent must exhaust that COBRA continuation coverage before qualifying for a HIPAA special enrollment. This means you must continue your COBRA coverage for the maximum COBRA period. If you or a dependent lose COBRA coverage due to nonpayment of COBRA Premiums or failure to pay those Premiums timely, you are not eligible for a special enrollment in the Delta plan. If COBRA is terminated for cause (such as fraud), there is not a special enrollment event.

If you lose coverage under another group health plan (as explained above) or marketplace coverage and qualify for a special enrollment right, you can add yourself and any dependents who also lost that other coverage — and who satisfy the plan's eligibility rules — to Delta medical and dental coverage. You may add yourself to coverage so that you may enroll your eligible dependents who lost eligibility for their other coverage even if you did not lose other coverage yourself. If you want to add only yourself to coverage, you must have experienced a loss of eligibility for the other coverage for a HIPAA-qualified reason.

New Dependent Special Enrollment (Marriage, Birth, Adoption or Placement for Adoption)

A new dependent special enrollment is granted:

- To retirees and COBRA participants enrolled in Delta medical and dental coverage at the time of the event, and
- To active and inactive eligible (including disabled) employees, regardless of whether they are enrolled in Delta medical and dental coverage at the time of the event

The new dependent special enrollment does not apply to vision coverage.

This special enrollment right differs from a qualified life event (which also includes birth, adoption, marriage and placement for adoption) because it allows you to add not only the new dependent, but yourself (if you are an active or inactive eligible employee who had opted out of Delta coverage) and other of your eligible dependents who had opted out of coverage (such as your Spouse or other children).

You have to enroll within 60 days after marriage, birth, adoption or placement for adoption.

If you enroll within 60 days after a birth, adoption or placement for adoption, coverage is effective on the day of the event that qualified you for a special enrollment. In the event of marriage, if you enroll within 60 days of the event, coverage is effective on the earlier of the 1st or the 16th day of the month after the event is reported.

You may be required to provide a copy of a certificate or other official paperwork showing the date of the event or proving the loss of other coverage.

CHIPRA Special Enrollment Rights

The following information and rules are required by federal law under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

If you are eligible for Delta health coverage, but are unable to afford the premiums, some states have premium assistance programs that can help you pay for coverage. (See more details on these state programs in “CHIPRA Special Enrollment Rights” in the “Plan Administration and Legal Notices” section of this handbook). In addition, CHIPRA permits additional special enrollment events under the following circumstances:

- You or your dependent loses coverage under Medicaid or a state Children’s Health Insurance Program (CHIP) due to loss of eligibility (other than non-payment of premiums)
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or a CHIP

You have to enroll within 60 days of the loss of coverage or of the determination that you are eligible for premium assistance in order to qualify for this special enrollment opportunity. If you enroll within 60 days, coverage is effective on the day of the event that qualified you for a special enrollment.

You may be required to provide a copy of a certificate or other official paperwork showing the date of the event or proving the loss of Medicaid or CHIP coverage.

If you have a CHIPRA special enrollment event, you must call the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** to report the event and make appropriate benefit election changes. If you think you or your dependents may be eligible for Medicaid or CHIP, you may call **1-877 KIDS NOW** or visit **www.insurekidsnow.gov** to find out how to apply. For other questions, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling **1-866-444-EBSA (3272)**.

How to Report a Life Event

Qualified life event changes are reported in different ways depending on the nature of the change. Following are the two methods available to all active, inactive and disabled employees, as well as retirees, survivors and COBRA participants.

Online Via Benefits Direct

You can go to Benefits Direct to report the following life events and make appropriate benefit election changes:

- Adoption/placement for adoption
- Birth
- Change in Spouse's work or benefit coverage
- Dependent gains eligibility
- Dependent loses eligibility
- Divorce
- Loss of other coverage - HIPAA (including marketplace coverage)
- Marriage

You can also make Health Savings Account (HSA) payroll deduction changes (you must be enrolled in an HSA Medical Option) in the same place on Benefits Direct as you would use to report qualified life events. However, an HSA payroll deduction change is not a qualified life event, and you can start, stop or change payroll contributions to an Optum Bank Health Savings Account at any time.

On Benefits Direct, look for the "Ready To Report a Life Event?" Box and click on "Go" to report a qualified life event change. If you are eligible, you can make benefit elections according to plan rules.

Note: If your qualified life event change involves new dependents, you are required to add them on the **My Dependents** page in **Self Service** or by completing a **Family Status Change Form** with the Employee Service Center (ESC) first. You may be asked to provide documentation confirming your dependents' eligibility. If you are unable to provide requested documentation, your dependent's coverage will end and plan benefits paid incorrectly may have to be repaid. For details on the required documentation, please see "Dependent Documentation Requirements" in the "Eligibility" section of this handbook.

Changing Your Benefits Online as a Result of a Qualified Life Event

- **Step 1:** Go to <https://deltanet.delta.com> and enter your 9-digit employee number (Username), along with your Delta Passport password
- **Step 2:** From the **Deltanet** home page, select **Self Service**
- **Step 3:** From the **Self Service** home page, select **Benefits Direct** to make eligible benefit elections

Benefits Direct allows you to review your current coverage and dependents that are on file, and make your election changes.

Note: Before you report qualified life event changes in Benefits Direct that involve your dependents, review and maintain your dependent information. From the **Self Service** home page, click on **My Dependents** to view, maintain or add dependent information. You may also submit a Family Status Change form with the Employee Service Center (ESC). Contact the ESC at **1-800 MY DELTA (1-800-693-3582)** for assistance.

It is your responsibility to maintain complete and accurate dependent data with Delta. Your failure to do so may result in the denial of eligibility and possible repayment of claims costs.

This online site/functionality described above is available to active and inactive employees as well as to retirees and survivors. International callers should contact the ESC by dialing **404-677-8000**.

With a Family Status Change Form

To report the following events and make benefit election changes, you must complete and submit a Family Status Change Form to the ESC, along with supporting documentation. Search for "Family Status Change" to access this form on Deltanet. Mail or fax completed forms to the address or fax number on the form. For details on the required documentation, please see "Dependent Documentation Requirements" in the "Eligibility" section of this handbook.

- Add a child
- Add a spouse
- Adoption/Placement for adoption
- Appointment as legal guardian for a child
- Change a child's dependent status
- Divorce or legal separation
- Death of a Spouse
- Death of a child
- Establishing incapacitated status for a child

Within 72 hours after you submit your Family Status Change Form, you must call the ESC at 1-800 MY DELTA (1-800-693-3582) to make sure your form was received.

HEALTHCARE BENEFITS HANDBOOK

Direct Bill and Direct Debit Participants

If you pay your Premiums through Direct Bill or Direct Debit invoicing, it is very important that you report any life event changes for a Spouse or other dependent within 60 days of the event. If you do not do so, ineligible dependents may continue to be covered, resulting in possible overpayments from the plan that you must repay.

If you are a retiree or survivor, you must continue to pay all required Premiums in full on a timely basis to be eligible for future enrollment opportunities, including Annual Open Enrollment. If benefits are cancelled for non-payment of Premiums, you **cannot** re-enroll in retiree/survivor benefits during a future annual open enrollment period.

When Changes Are Effective

The table below summarizes when changes to your benefits as a result of different life events become effective. You must report the event and make changes to your benefits via online reporting or via telephone **within 60 days of the qualified life event change**.

Benefit Effective Dates	1st or 16th of the Month Following Receipt by ESC of the Request for Change	Event Date
Birth or adoption		X
Marriage	X	
Change in Spouse's coverage	X	
Divorce		X
Dependent gains eligibility/full-time student change (after 90-day extension)	X	
Dependent turns 19/child or student ages out	X	
Retirement	X (if retirement date is not 1 st of the month, then either the 1 st or 16 th of the month following event date)	X (if retirement date is 1 st of the month)
Retiree/spouse/child become Medicare eligible		X
Death of Spouse or child		X
Death of active employee or retiree (active coverage ends for survivors)	X	
Survivor coverage begins (following date of death)	X	
Loss of other coverage (including marketplace coverage)	X	
Change to status that is ineligible for benefits	X	
Change to status that is eligible for benefits	X (ground, flight attendant, flight dispatcher employee)	X (pilot)
Move to/from a UHC or HMO service area	X	
Drop coverage due to enrollment in exchange plan	X	
End of COBRA		X

If You Do Not Report Your Life Event Within 60 Days

Active Employees

If, **within 60 days of the qualified life event change**, you do not report the event and make changes to your benefits via online reporting or via telephone for CHIPRA special enrollment events — or if the ESC does not receive your completed Family Status Change Form (including the required documentation) for those events requiring the form (see “With a Family Status Change Form” earlier in this “Life Events” section) — you cannot change your benefits or add/drop dependents until the next annual open enrollment period.

Important Note: If your dependent is losing eligibility for coverage as a result of the life event (for example, divorce), it should be reported even if 60 days have passed. Dependents who lose eligibility are automatically removed from coverage.

Inactive or Disabled Employees on Leave of Absence

If, **within 60 days of the qualified life event change**, you do not report the event and make changes to your benefits via online reporting or via telephone for CHIPRA special enrollment events — or if the ESC does not receive your completed Family Status Change Form (including the required documentation) for those events requiring the form (see “With a Family Status Change Form” earlier in this “Life Events” section) — you cannot change your benefits or add/drop dependents until the next annual open enrollment period. However, inactive pilots who do not add new dependents within the 60 days, will not be able to enroll the new dependent until the pilot returns to active payroll status. However, if you retire or die while on inactive status and are eligible for medical/dental benefits, you or your survivors will be given an opportunity to enroll in Delta coverage.

Important Note: If your dependent is losing eligibility for coverage as a result of the life event (for example, divorce), it should be reported even if 60 days have passed. Dependents who lose eligibility are automatically removed from coverage.

Retirees

If, **within 60 days of the qualified life event change**, you do not report the event and make changes to your benefits via online reporting or via telephone for CHIPRA special enrollment events — or if the ESC does not receive your completed Family Status Change Form (including the required documentation) for those events requiring the form (see “With a Family Status Change Form” earlier in this “Life Events” section) — you can never add the late-reported dependent to your retiree medical or dental coverage. If you are not enrolled in coverage at the time you report the qualified life event, you can never enroll your newly qualified dependent in medical and dental benefits; however, you may enroll yourself during future annual open enrollment periods.

Important Note: If your dependent is losing eligibility for coverage as a result of the life event (for example, divorce), it should be reported even if 60 days have passed. Dependents who lose eligibility are automatically removed from coverage.

COBRA Participants

If, **within 60 days of the qualified life event change**, you do not report the event to the ESC, you cannot change your benefits to accommodate the life event or add the dependent to your COBRA coverage during the year. However, at the next annual open enrollment period, you may be able to add the dependent to your COBRA coverage or change your elections. Refer to the "COBRA Continuation Coverage" section for more details. If a dependent loses coverage due to a life event, it should always be promptly reported since it ends eligibility for COBRA coverage.

Continuing Medical, Dental, Vision and FSA Coverage While Absent From Work

Depending on the reason for your absence, different rules apply to how you may continue your medical, dental or vision coverage and FSA election while you are not actively at work.

Leave of Absence

If you are an active full-time or part-time employee and are granted an approved leave of absence, you may be able to continue your medical, dental, vision and/or FSA coverage under the healthcare plans offered by Delta, depending on the type of leave you take. The type of leave determines if you pay active Employee Contributions or 100% Premiums, or if you must elect COBRA coverage to continue your benefits. Each leave is administered individually and is outlined under "Disabled Employees" and "Inactive Employees" in the "Eligibility" section of this handbook.

Additional resources regarding the various leaves of absences at Delta can be found by calling the ESC, contacting your Human Resources representative or the Chief Pilot's office. You may also review the *Disability Benefits Handbook* (a summary plan description) for your employee group on Deltanet.

You may be eligible to continue your medical, dental and/or vision benefit coverage while on the following types of leaves of absences:

- Medical and Disability leave
- Family and Medical Leave (FMLA)
- Military leave
- Personal leave
- Disciplinary leave
- Furlough and workforce leave

HSA Contributions While on Leave

If you go off active pay status during the year and wish to continue contributing to your Optum Bank HSA, you must arrange to directly deposit funds into your account on a post-tax basis. You are responsible for monitoring your applicable annual limit to make sure you do not over-contribute. Note that Delta pays the monthly account maintenance fee for the Optum Bank HSA, but other fees may apply.

Medical and Disability Leave (Including Paid Maternity)

Depending on the type of leave and your employee group, you may elect to continue your medical, dental and/or vision coverage and participation in a Healthcare FSA for a specified period of time during your authorized medical, paid maternity or disability leave. If you request and are granted one of many types of medical or disability leaves of absences, the leave that you take determines the duration and cost of your benefits. Some medical and disability leaves require that you pay 100% of the cost of your benefits while on leave or elect COBRA coverage. Other medical and disability leaves allow you to pay active Premiums through deductions from your continued pay protection or Direct Bill invoicing. Refer to the "Eligibility" section of this handbook for more information.

Family and Medical Leave

The Family and Medical Leave Act of 1993 (FMLA) provides eligible employees with up to 12 weeks, during an applicable rolling 12-month period, of job-protected leaves of absence for certain family and medical reasons.

During an approved family medical leave, you may maintain the same medical, dental and vision coverage (if any) that you had immediately before the leave began. If you participate in a Healthcare FSA and:

- You are a regular full-time ground employee, regular part-time ground employee, flight attendant or flight dispatcher you may continue contributing to the account on a pre-tax basis if using vacation or PPT while on FMLA, as well as while you receive paid maternity leave, certified time or OJI pay. If you are on short-term disability, long-term disability or an unpaid leave, your Healthcare FSA deductions are after-tax. Note that Healthcare FSA deductions are allowed only through the end of the year in which your leave started
- You are a pilot, you may continue contributing to the account on a pre-tax basis if receiving disability benefits from the Delta Pilots Disability and Survivorship Plan, on paid maternity leave, or using vacation while on FMLA. If your FMLA leave is unpaid, you may elect COBRA coverage for your Healthcare FSA, which may stay in place only through the end of the year in which your leave started

If you qualify for unpaid FMLA leave of absence, you may do any of the following when you begin leave or return to work after taking leave:

- Continue to participate in the plan by making required active Premiums
- Change certain benefit elections
- Terminate participation in the plan

Any changes to your benefit elections can be made for yourself and your dependents.

Your active Premiums are made by paying them directly to Delta via Conduent HR Services LLC Direct Bill invoicing for 12 weeks. Delta will invoice you monthly for your Premiums. If you do not pay the required Premium, your coverage will lapse. Send your Premium payments to:

Conduent HR Services LLC for Delta Air Lines
P.O. Box 382119
Pittsburgh, PA 15251-8119

If you fail to return to work and you had continued coverage throughout your FMLA leave, coverage may be available under COBRA. Also, if you fail to return to work within 30 days of the expiration of your FMLA leave, you may be required to repay the Premiums paid by Delta on your behalf to

maintain your coverage while on the leave. When you return to active employment directly from family medical leave (in the same calendar year), the coverage in effect before the leave began continues on your first day back.

Military Leave

Depending on your employee group and the particular type of military leave you are taking, you may elect to continue your medical, dental and/or vision coverage and participation in a Healthcare FSA for a specified period of time during your authorized military leave.

If you are granted a military leave of absence, the leave that you take and your employee group determine the cost of your benefits. Delta may pay the cost of your benefits for a specified period of time or require you to pay active Premiums or the full cost of your benefits. To learn more about continuing your coverage during a military leave, contact the ESC at **1-800 MY DELTA (1-800-693-3582)**.

Personal Leaves

If you are on an authorized short-term or extended personal leave, you can elect to continue, for a specified period of time, the medical, dental and/or vision coverage that you were enrolled in at the time your leave began. Your employee group and the type of personal leave you select will determine the duration of your leave and the amount you must pay to continue coverage. For more information about personal leave, contact the ESC at **1-800-MY DELTA (1-800-693-3582)**.

Disciplinary Leave

If you are subject to disciplinary leave, the type of disciplinary leave and your employee group will determine if and how long you are eligible to continue medical, dental and/or vision benefits as well as participation in a Healthcare FSA and the cost to continue those benefits. For more information about disciplinary leave, contact the ESC at **1-800 MY DELTA (1-800-693-3582)**.

Furlough/Workforce Leave

If you go on furlough, a company convenience leave of absence or other type of workforce leave, your work group and the type of furlough, workforce or other company convenience leave will determine the length of the leave and the cost to continue medical, dental and/or vision benefits as well as participation in a Healthcare FSA. For more information about furlough/workforce leave, contact the ESC at **1-800 MY DELTA (1-800-693-3582)**.

During Total Disability

If you receive disability benefits under the Delta disability plans, or were placed on an unpaid approved disability leave of absence (flight attendant, ground and flight dispatcher employees only), your healthcare coverage (medical, dental or vision) continues at the same level that was in effect for you and any eligible dependents. You continue to pay any Premiums that you were paying while on active payroll status. However, these costs are deducted from your disability check on a post-tax basis (pre-tax basis for pilots receiving disability benefits from the Delta Pilots Disability and Survivorship Plan) while you are receiving disability benefits.

If you participate in a Healthcare FSA and/or Dependent Care FSA, you may continue contributing to the account(s) while on active payroll status, which includes any time on sick leave (for pilots), vacation or PPT (for flight attendant, ground and flight dispatcher employees). However, once you transition to an approved disability status, your eligibility to participate in the FSAs change. Note that pilots who transition to approved disability status will be given a benefit enrollment opportunity in the event you would like to have pre-tax contributions to your Healthcare FSA and/or Dependent Care FSA deducted from your disability pay. Keep in mind, you had to have been contributing to either of these FSAs prior to going on approved disability status in order to have this benefit enrollment opportunity.

In addition, if you are a pilot contributing to an Optum Bank Health Savings Account (HSA), those contributions may also be made on a pre-tax basis from your disability pay if you elect to do so.

For more information about continued eligibility for medical, dental and FSA benefits while on an approved leave of absence or disability, see the "Eligibility" and "Flexible Spending Accounts" sections of this handbook.

The ESC Can ...Process Your Life Event

When you have a major life event, you can call the ESC at **1-800 MY DELTA (1-800-693-3582)** to learn:

- ◆ Whether your event qualifies as a life event change
- ◆ Whether you report your event on Benefits Direct or through the ESC directly or with a Family Status Change Form
- ◆ If your ESC Family Status Change Form has been received by the ESC
- ◆ If you qualify to make benefit changes consistent with your life event
- ◆ How you can make benefit changes
- ◆ How you can continue benefits while absent from work

THINKING ABOUT RETIRING

THINKING ABOUT RETIRING

If retirement from Delta might be in your near future, you will have many decisions to make. One of the things you will need to consider is whether you are eligible and want to continue your healthcare benefits into retirement for you and your family.

Understanding that your needs may change at retirement, Delta will give you an enrollment opportunity to continue, change or discontinue the Delta healthcare coverage you had before retirement, if you are eligible for these coverages. You can change your medical, dental and/or vision options, and drop or add eligible dependents. Remember, if you choose to discontinue coverage, current enrollment rules allow eligible retirees to re-enroll during a future annual open enrollment period.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

Your Retiree Healthcare Coverage Options

You have several options to consider for your healthcare coverage in retirement. You should compare each option based on what the coverage costs and what it offers. Be sure to review out-of-pocket costs, prescription drug lists and physician and provider networks to get a sense of the full impact on you and your family.

The Health Insurance Marketplace

If you or your family members are under age 65, the Health Insurance Exchanges under the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA) currently provide you with affordable health coverage options with no pre-existing limitations.

You can choose from health plans offered on the federal or state exchanges, depending on where you live. In some states, the state runs its Health Insurance Exchange. In others, it may be run by the federal government.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

Delta has no role in the Health Insurance Exchange plans and does not provide any portion of the cost of these plans. But, if you qualify, you may be eligible for federal subsidies that will reduce the cost you pay for health insurance purchased through the Health Insurance Marketplace. Eligibility is based on household income and other factors.

To find out more about your options under the Marketplace and about enrolling, including when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

Delta Retiree Healthcare Coverage

Eligibility for Delta's retiree healthcare benefits are based on many factors, including age and regular ground employee or pilot status:

- **Under age 65:** Retiree medical, dental and vision benefits under the Delta Account-Based Healthcare Plan (DABHP) are available to Delta retirees and/or their eligible dependents under age 65 if the retiree meets the eligibility requirements (for more information about eligibility for retiree healthcare benefits, see the "Eligibility" section of this handbook – under the "Eligible Participants" heading, look for section called "Retirees")
- **Age 65 or older:** Retirees and/or their eligible dependents age 65 or older are not eligible to enroll in DABHP medical and dental options or in Delta vision coverage

If you are a Delta pilot retiree or survivor, you also have the option of coverage under the Delta Pilots Medical Plan (DPMP). Medical coverage under the DPMP, as well as vision coverage, is available to eligible pilot retirees and survivors before and after age 65 (for certain retirees). For information on the DPMP, see the *Delta Healthcare Benefits Handbook: Delta Pilots Medical Plan*.

Are You Eligible for Medicare?

The Insurance Trust for Delta Retirees sponsors a Medicare Supplement Plan that Delta retirees and employees who are eligible for Medicare (age 65) may consider. This plan is not associated with or controlled by Delta. If you or one of your eligible dependents are age 65 or older, you will receive an enrollment package from the Insurance Trust for Delta Retirees for medical, dental, prescription drug and vision coverage. If you wish to enroll, follow the instructions in the package from the Retiree Service Center (Mercer), who is the administrator of the Insurance Trust for Delta Retirees plan. Delta's Employee Service Center (ESC) will not be able to enroll you in the Insurance Trust for Delta Retirees Medical Plan or answer questions regarding the Insurance Trust for Delta Retirees plan coverages. For details about the Insurance Trust for Delta Retirees Medical Plan, refer to the materials that will be mailed to your home or contact the Retiree Service Center (Mercer) at **1-877-325-7265**.

COBRA Continuation Coverage

If you are enrolled in Delta medical or dental coverage when you retire, you are eligible to elect COBRA continuation coverage, which generally lasts up to 18 months from your retirement date, at which time you can enroll in Delta retiree healthcare coverage, if eligible.

See "COBRA Continuation Coverage" later in this "Thinking About Retiring" section for additional information. For full details about COBRA — including the enrollment process — see the "COBRA Continuation Coverage" section of this handbook.

Attention Delta Vacations Employees

Delta Vacations does not provide access to Company-provided healthcare benefits after retirement. Therefore any Delta retiree healthcare benefits described in this handbook are not applicable to Delta Vacations retirees. However, former Delta Vacations employees may be provided an election for COBRA continuation coverage after retirement and may consider individual coverage through the Health Insurance Marketplace. See the "COBRA Continuation Coverage" section of this handbook for more information about COBRA rights.

Making the Decision to Retire

Once you decide to retire from Delta, you will need to notify your manager or supervisor of your intent to retire and intended retirement date. Your department should process your retirement status in the Delta HR system, which must be done before you will be sent information about your retiree healthcare elections, if you are eligible.

If you are a Delta ground, flight dispatcher or flight attendant employee or were a pre-merger Northwest pilot, you can find detailed information about your pension plan benefits, and request information about these benefits, on Benefits Direct.

Selecting Healthcare Benefits for Your Retirement

Once your retirement has been processed, here is how you elect healthcare coverage:

- If you are eligible, you will receive a letter in the mail notifying you that you may make your Delta retiree healthcare coverage elections
 - *If you are a pilot*, you will be able to elect medical, dental and vision retiree coverage. If you also have eligible dependents under age 65, you will be able to elect medical, dental and vision coverage for you and your eligible dependents
 - *If you are a ground, flight dispatcher or flight attendant employee under age 65 with eligible dependents under age 65*, you will be able to elect medical, dental and vision retiree coverage for you and your eligible dependents
 - *If you are a ground, flight dispatcher or flight attendant employee under age 65 and your dependents are over age 65*, retiree healthcare benefit elections will be extended only to you
 - *If you are a ground, flight dispatcher or flight attendant employee over age 65 with eligible dependents under age 65*, retiree healthcare benefit elections will be extended only to your dependents
 - *If you are a ground, flight dispatcher or flight attendant employee age 65 or older with dependents age 65 or older*, neither you nor your dependents will be offered medical, dental or vision retiree coverage

Note that, in addition to healthcare coverage, the notification letter you receive will inform you of your eligibility to continue certain voluntary insurance coverage as a retiree. See the *Life Insurance and Survivor Benefits Handbook* for more information about post-retirement eligibility for this coverage

- If you or your dependents were enrolled in Delta coverage immediately before your retirement, you will be extended an election to continue the coverage type (medical, dental and/or vision) you had as an active employee through COBRA continuation coverage. You may do this instead of electing retiree healthcare benefits at the time of your retirement. The differences between COBRA coverage and retiree medical will be explained in your Retirement Enrollment Notification. The Employee Service Center (ESC) will mail a separate COBRA Qualifying Event Package to you
- Within two weeks following your retirement date, the retiree benefits notification letter will be mailed to your home address. The COBRA Qualifying Event Package (with your Enrollment Worksheet) will also be mailed to your home address around the same time

- Decide whether you want to elect Delta retiree healthcare benefit coverage, if eligible, COBRA continuation coverage, or seek other options such as through the Health Insurance Marketplace. If you want to elect Delta retiree benefits, follow the instructions in the notification letter and enroll on Benefits Direct. If you want to elect COBRA coverage, review your Enrollment Worksheet in your COBRA Qualifying Event Package with instructions to complete your COBRA enrollment on Benefits Direct. For more information about health insurance options available through the Marketplace, visit **www.healthcare.gov**
- If you elect coverage through Delta or COBRA continuation benefits, once benefits are elected and Premiums are timely paid, your healthcare benefit coverage will be effective back to your date of retirement

View Delta Retiree Medical and COBRA Premiums Online

The 2019 retiree medical and COBRA Premiums are available on Benefits Direct:

- Visit Deltanet at **<https://deltanet.delta.com>**
- Click on "Self Service"
- Click on "Benefits Direct"

Delta Healthcare Options Available in Retirement

If you are a Delta employee enrolled in Delta healthcare benefits at the time you retire — or even if you are enrolled in the "No Coverage" option — you have several options for retiree healthcare coverage if you are eligible. You may enroll in the:

- Delta Account-Based Healthcare Plan (DABHP), which is available to Delta pilot, ground and flight attendant retirees until age 65

Medical Options

- Retiree & Survivor Bronze HSA Medical Option
- Retiree & Survivor Bronze Out-of-Area (OOA) HSA Medical Option (if you live outside the network service area)

Dental Options

- Basic Dental Option
- Comprehensive Dental Option
- Health Maintenance Organizations (HMOs), which are available to certain Delta retirees based on living in an HMO service area
 - Health Plan Hawaii
 - Humana Health Plan of Puerto Rico
- Vision coverage through EyeMed
- "No Coverage" option for medical, dental and/or vision coverage

See the "Medical Benefits" section of this handbook for a complete description of the benefits of each of the DABHP and HMO healthcare benefit options listed above. For information on dental and vision coverage, see the "Dental Benefits" and "Vision Benefits" sections of this handbook.

Enrollment in Delta Retiree Coverage Mid-Year and During Annual Enrollment

Under current enrollment rules, as long as you and your dependents remain eligible, you may enroll yourself and eligible dependents in a Delta retiree healthcare benefit option during a future enrollment period (DABHP options are only available until age 65). You may be asked to provide proof that your other medical coverage has ended.

However, once you or your eligible dependent reaches age 65, the over-age 65 family member is no longer eligible to participate in retiree medical, dental and vision benefits, and cannot opt in and out of Delta coverages (except for certain pilots who continue to have the DPMP available to them after age 65, as described in the *Delta Healthcare Benefits Handbook: Delta Pilots Medical Plan*).

If you enroll in Delta retiree medical and you want to drop that Delta coverage mid-year, you must first show proof to the ESC that you have other coverage. This means that you must provide an insurance card with an effective date or a letter from an insurer showing that you have other coverage.

COBRA Continuation Coverage

If you are enrolled in Delta medical or dental coverage when you retire, you are eligible to elect COBRA continuation coverage, which generally lasts for up to 18 months. You also may elect retiree coverage right away, if you are eligible, but many retirees who are offered COBRA continuation coverage choose to take advantage of it because:

- It may be a less expensive option for the same coverage because Premiums for COBRA continuation coverage are based on the claims experience of active employees only
- You have the option of changing the medical or dental option in which you wish to be enrolled during your COBRA continuation period. If you choose retiree coverage right away instead of COBRA continuation coverage, the Retiree & Survivor Bronze HSA Medical Option or Retiree & Survivor Bronze OOA HSA Medical Option will be your only available DABHP retiree medical option
- Whenever your COBRA coverage period ends (typically, at the end of 18 months), you may immediately enroll in the Delta retiree medical option without having to wait for the annual open enrollment period. This means that, as long as you follow the proper enrollment procedures in a timely manner (for instance, you notify the ESC within 60 days of the end of your COBRA coverage that you want to enroll in retiree coverage), and your COBRA Premiums are timely paid, you should not have any lapse in coverage. Alternatively, once you've exhausted your COBRA continuation coverage, you'll be eligible to enroll in Health Insurance Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended

If a COBRA participant waives COBRA coverage at any time, the COBRA coverage cannot be reinstated in the future for any reason.

Full details about COBRA coverage — including the enrollment process — appear in the "COBRA Continuation Coverage" section of this handbook.

When considering your options under Delta retiree coverage, COBRA continuation coverage, or a Marketplace plan or other health coverage...

You should investigate and understand the following:

- ◆ **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA continuation coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive
- ◆ **Provider Networks:** If you're currently receiving care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage
- ◆ **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage
- ◆ **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations
- ◆ **Other Cost-Sharing:** In addition to Premiums or contributions for health coverage, you probably pay Copayments, Annual Deductibles, Coinsurance or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly Premiums, but a much higher Annual Deductible and higher Copayments

Questions About Your Delta Retiree Healthcare or COBRA Benefits?

Call the ESC at **1-800 MY DELTA (1-800-693-3582)**. International callers should dial **404-677-8000**.

Questions About The Health Insurance Marketplace?

Visit **www.healthcare.gov**.

COORDINATION OF BENEFITS; SUBROGATION AND RIGHT OF RECOVERY TERMS

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to you if you are covered under more than one health benefits plan. Your health coverage through Delta coordinates with other non-Delta group plans that may cover you and/or your dependents. Coordination of Benefits helps prevent duplication of benefit payments for the same services. It is your responsibility to notify the applicable benefits administrator (for example, UHC or MetLife) if you are covered by other medical and/or dental plans.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

Coordinating Benefits With Other Health Plans

The following types of plans normally coordinate benefits:

- Any group insurance program that provides healthcare benefits or services, including self-insured plans
- A medical component of a group long-term care plan, such as skilled nursing care
- Student coverage sponsored by or provided through an educational institution
- No fault or traditional "fault" type medical payment benefits or personal injury protection (PIP)
- Medical payment benefits under any premises liability or other types of liability coverage
- Medicare or other government-sponsored programs, as permitted by law

Your health coverages consider any benefits to which you may be entitled from other group plans (even if you do not request payment from them) when determining the benefit payments made under the plans offered by Delta.

Attention Employees Married to Another Employee

Employees, retirees and survivors and their dependents (Spouses and eligible children) are only permitted to be enrolled once in the Delta Account-Based Healthcare Plan, regardless of marital status or relationship to other Delta employees (or retirees).

Medical/Dental/Vision Coverage

If both you and your Spouse or child are eligible for the Delta Account-Based Healthcare Plan, you cannot be covered under the Plan as both an employee, retiree or survivor (a "primary plan member") and a dependent of another primary plan member. Your coverage options are:

- ◆ Be covered individually as the primary plan member only, or
- ◆ Be covered as the primary plan member with your Spouse or eligible child covered as your dependent (or vice versa)

In the event you and your Spouse (or ex-Spouse) have children eligible for medical coverage only **one** parent (or step parent) may cover the child as a dependent. If your child is a primary plan member, the child may not also be enrolled as a dependent on a retiree's, survivor's or employee's coverage.

How Coordination With Other Group Plans Works

If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then the other plan(s) – the secondary plan(s) – may pay additional benefits, after considering the benefits paid by the primary plan.

If your health coverage under the Delta plan is your primary plan, the Delta plan pays benefits up to the limits described in this handbook.

When the Delta coverage is the secondary plan, it figures its regular benefit as if it were primary and then subtracts the benefit amount actually paid by the primary plan, and pays the difference, up to the amount the Delta plan would have paid if primary.

Tricare Standard (Formerly Known as CHAMPUS)

The Civilian Health And Medical Programs of the Uniformed Services provides a comprehensive program of health care for active-duty and retired service personnel and their dependents, and dependents of deceased military personnel. Tricare Standard is a law and not a health plan. CHAMPUS law requires that your Delta plan administered by UnitedHealthcare will always pay primary to any Tricare Standard benefits.

However, if an employee enrolled in the TRICARE Supplement Plan offered through Association & Society Insurance Corporation (ASI) during Annual Open Enrollment, the employee is not enrolled in the Delta plan. The TRICARE Supplement Plan, elected by the employee in lieu of a Delta-provided benefit option, will pay secondary to TRICARE.

Determining the Order of Payment

When benefits coordinate, the plans determine which one pays benefits first (called the "primary plan" or "primary") in the following order:

1. Medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy will always pay primary to the Delta plan
2. The plan with no coordination of benefits provision is primary
3. The plan covering the person as an employee rather than as a dependent is primary
4. If you are receiving COBRA continuation coverage under another employer plan, the Delta plan pays primary
5. When the plans of parents who are either married, living together without being legally separated, or have joint custody, but no court order specifying which parent must provide health coverage both cover a child, the plan of the parent whose birthday comes earlier in the calendar year is the primary plan. If both parents have the same birthday, the primary plan is the one that covered the dependent longer
6. In the case of a divorce or separation where there is no court order specifying the parent that is responsible for health coverage, the plan of the parent who has custody of the dependent child pays benefits primary; then the plan of the Spouse of the parent with custody pays primary; then the plan of the parent without custody pays third. If there is a court order requiring a parent to take financial responsibility, then that parent's plan is always primary
7. Plans for active employees pay before plans covering laid-off or retired employees
8. The plan that has covered the person the longest is the primary plan
9. If none of the above rules determines which plan is primary, the allowable expenses are shared equally between the plans. In addition, the Delta plan will not pay more than it would have paid had it been the primary plan

How Secondary Benefits Are Determined

If the Delta plan pays secondary to any plan other than Medicare, then:

- The Delta plan determines the amount it would have paid based on the allowable expense
- If the Delta plan would have paid less than the primary plan paid, the Delta plan pays no benefits.
For example: Assume the primary plan pays at 80% and if the Delta plan were primary it would pay at 80%. As secondary plan, the Delta plan will pay the difference between what the primary plan paid, and what the Delta plan would have paid as primary, after the Deductible is met. In this case, $80\% - 80\% = 0\%$
- If the Delta plan would have paid more than the primary plan paid, the plan will pay the difference.
For example: Assume the primary plan pays at 70% and if the Delta plan were primary would pay at 80%. As the secondary plan, the Delta plan will pay the difference between what the primary plan paid, and what the Delta plan would have paid as primary. In this case, $80\% - 70\% = 10\%$. This example assumes that the Delta plan Deductible was met

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense if This Plan Is Secondary

If the Delta plan is secondary, the allowable expense is the primary plan's network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and the Delta plan do not have a network rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

What is an allowable expense?

For purposes of coordination of benefits, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

Filing Claims With Two Group Plans

To speed up reimbursement of claims when you or your dependent are covered under more than one group plan, file the claim with the primary plan first. When that process is complete and you have received the Explanation of Benefits (EOB) from the primary plan, submit the claim with a copy of the itemized bill and a copy of the EOB to the secondary plan. The secondary plan cannot process the claim without the EOB from the primary plan.

How Coordination With Medicare Works

Your medical benefits may coordinate with Medicare. How the Plan coordinates with Medicare depends on your age and whether you are an active employee, an inactive employee, a retiree or survivor.

Under current law, Medicare eligibility begins at age 65. If you or your Spouse or dependents become Social Security disabled, you may become eligible for Medicare before age 65.

The following information pertains to employees and retirees who become Medicare eligible or whose covered dependent becomes Medicare eligible. It explains when Medicare pays primary and when the Delta plan pays primary.

NOTE: If you are *eligible for, but not enrolled in Medicare, and the plan pays secondary to Medicare, benefits payable from the Delta plan will be reduced by the allowable expense that would have been paid if you had been enrolled in Medicare.*

If You Are an Active Employee

If you are an employee with an active current employment status who is age 65 or older and you or your dependent/Spouse are Medicare eligible due to reaching age 65 or otherwise, **Delta's medical plan is primary** and pays benefits as described in this handbook and the plan.

You must notify the ESC no later than 60 days after the date you or your dependent/Spouse enroll in Medicare.

End Stage Renal Disease (Active Employees)

If you or your covered dependent has end-stage renal disease, the **Delta plan pays primary** during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant.

Thereafter, Medicare becomes primary. If you or your covered dependent has end-stage renal disease and Medicare becomes primary, you must enroll in Medicare because the Delta medical coverage will pay *secondary* after the first 30 months, even if you do not enroll in Medicare. Contact your local Social Security Administration office for more information about enrolling in Medicare.

If You Are an Inactive Employee

If you are an inactive employee (for example, you are on a leave of absence, other than for disabilities described in the next paragraph) and you or your dependent/Spouse is Medicare eligible, **the Delta plan is generally primary** regardless of your or your covered Spouse's age.

If you are receiving Delta long-term disability benefits (and, as a result, are no longer considered in current employment status), and you or your dependent/Spouse is Medicare eligible, then **Medicare pays primary** for that Medicare-eligible individual. Since the Delta plan will pay secondary, *whether or not* you enroll in Medicare, you should strongly consider enrolling in Medicare under these circumstances.

You must notify the ESC no later than 60 days after the date you or your dependent/Spouse enroll in Medicare.

If You Are a Retiree or Survivor Under Age 65

If you are a retired Delta employee or a survivor under age 65, eligible for the Delta medical plans and eligible for Medicare, **Medicare is primary** for you. Also, if you are retired and your dependent/Spouse is under age 65 and eligible for Medicare, then **Medicare is primary** for your dependent/Spouse. Since the Delta plan will pay secondary, *whether or not* you enroll in Medicare, you should strongly consider enrolling in Medicare under these circumstances.

You must notify the ESC no later than 60 days after the date you or your dependent/Spouse enroll in Medicare.

If You Are a Retiree or Survivor Over Age 65

Note that the Delta Account-Based Healthcare Plan (DABHP) does not cover retirees, survivors or their Spouses or dependents once the individual reaches age 65. (Refer to the "Thinking About Retiring" section of this handbook for details about retiree medical coverage and the types of coverage that may be provided through other sources for Delta retirees, Spouses and survivors age 65 and older.) Please note that certain retired pilots may continue to be enrolled in the Delta Pilots Medical Plan after reaching age 65, as described in the *Healthcare Benefits Handbook: Delta Pilots Medical Plan*.

Report to the ESC Within 60 Days If You, Your Spouse or Other Dependent Begin Receiving Medicare Benefits

Please notify the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** once you or your dependent (including your Spouse) begin receiving Medicare benefits before turning 65 years old. You must report this change within 60 days of the event.

If the Delta plan pays secondary (see the rules above), you or the Medicare eligible family member will be moved to the Out-of-Area Medical Option associated with your Delta plan coverage. For individuals who are eligible for Medicare due to turning 65 years old, this coverage change will become effective on the 1st of the month of their 65th birthday or the 1st of the prior month if the individual turns 65 years old on the 1st of a month. For individuals who are eligible for Medicare benefits prior to age 65, this coverage change will become effective on the earlier of the 1st or the 16th day of the month after a copy of the Medicare card is received by the ESC.

If you are required to report Medicare enrollment to the ESC (see previous paragraph), but do not do so, you will continue to be charged the non-Medicare premium rates, your coverage will not be changed to the Out-of-Area Medical Option, if applicable, and your medical benefits will not be coordinated with Medicare as described in this section until you report the change. No retro-active payments will be made for care received prior to the coverage change.

Determining the Allowable Expense When This Plan Is Secondary to Medicare

If this plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with the plan benefits, will not exceed 100% of the total allowable expense and the maximum combined payment you can receive from Medicare and this plan may be *less than* 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, **and** this plan is secondary to Medicare, benefits payable from this plan will be reduced by the allowable expense that would have been paid if you had been enrolled in Medicare.

How Benefits Are Determined When Medicare Is Primary

If the Delta plan is secondary to Medicare, your Delta benefits are calculated based on the allowable expense. **Remember, even if you are not enrolled in Medicare, the Delta benefit is calculated as if you are:**

- ◆ First, your benefit is calculated as if the Delta plan were primary based on the allowable expense, if applicable
- ◆ Then, the amount of the allowable expense is subtracted from the amount the Delta plan would have paid if it had been primary
- ◆ Your Delta benefit is the difference between what the Delta plan would have paid (after your Deductible and Out-of-Pocket Maximums are met) had it been primary and the amount Medicare pays

Please see the following page for examples of how benefits are calculated when Medicare is primary.

If you have questions about coordinating Medicare and Delta benefits, please contact UnitedHealthcare by calling Delta Health Direct at **877-912-1820**.

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Examples

The following examples show how the Delta medical plans coordinate with Medicare when Medicare is primary and the Delta options are secondary.

In this first example, the Deductible and the Out-of-Pocket Maximum (OOP Max) of the Delta medical option have already been met; therefore the Delta plan, if primary, would pay 100% of covered expenses. Since Medicare pays only 80%, the balance is paid by the Delta plan.

First, let's determine what Medicare and the Delta medical plan each pay, if primary, for the same covered expense.

Medicare Allowable Expense	\$180.36	Delta Medical Plan Allowable Expense	\$180.36
Medicare Coinsurance	80%	Delta Medical Plan Coinsurance	100%
Medicare Pays	\$144.29 (\$180.36 x 80%)	Delta Medical Plan Benefit	\$180.36 (\$180.36 x 100%)

In this example:

- The Delta medical plan pays \$36.07: The amount the Delta medical plan would pay if primary (\$180.36) minus the amount paid by Medicare (\$144.29) [$\$180.36 - \$144.29 = \36.07]
- You pay \$0: The remaining balance of the allowable charge (\$180.36) after what is paid by both Medicare (\$144.29) and the Delta medical plan (\$36.07) [$\$180.36 - (\$144.29 + \$36.07) = \0]

In the second example, the Deductible has been met, but the OOP Max has not; therefore the Delta medical plan, if primary, would pay 80% of covered expenses.

Medicare Allowable Expense	\$180.36	Delta Medical Plan Allowable Expense	\$180.36
Medicare Coinsurance	80%	Delta Medical Plan Coinsurance	80%
Medicare Pays	\$144.29 (\$180.36 x 80%)	Delta Medical Plan Benefit	\$144.29 (\$180.36 x 80%)

In this example:

- The Delta medical plan pays \$0: Both Medicare and the Delta medical plan would pay 80% of the allowable charge as the primary plan. Therefore, the combined benefits paid from Medicare and the Delta medical plan cannot exceed 80% of the allowable charge, or in this case \$144.29. Since this is what Medicare pays as the primary plan, no additional benefits are paid from the Delta medical plan
- You pay \$36.07: The remaining balance of the allowable charge (\$180.36) after what is paid by both Medicare (\$144.29) and the Delta medical plan (\$0) [$\$180.36 - (\$144.29 + \$0) = \36.07]. This will be applied to the Delta medical plan OOP Max. (If the Deductible for the Delta medical plan had not yet been met, the unpaid portion would also be applied to the annual Deductible)

Right to Receive and Release Needed Information

The claims administrator of the Delta plans has the right to exchange information about benefit payments with other insurance companies, organizations or individuals in order to coordinate benefits. The claims administrator also can make or recover payments. In addition, the claims administrator of the Delta plans has the right to request from you or your covered dependents information about other plans in which you or your dependent may participate. If you or your covered dependent does not provide requested information within 90 days, the claim may be denied.

Subrogation and Right of Recovery Terms

This section includes information on how your benefits are impacted if you suffer a sickness or injury caused by a third party. The following terms are specifically used and referred to with regard to the right to subrogation and the right of recovery for the Delta Account-Based Healthcare Plan (DABHP).

“Responsible Party” means any party, person or entity actually, possibly or potentially responsible for making any payment to a Covered Person, under any legal liability theory, including equitable or legal liability, due to a Covered Person’s injury, illness or condition. The term “Responsible Party” includes, but is not limited to, the liability insurer or other indemnifier of such party or any Insurance Coverage.

“Insurance Coverage” refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile insurance coverage, Personal Injury Protection coverage, automobile medical payment coverage or any first party insurance coverage. This plan is always secondary to automobile medical payment, no fault and Personal Injury Protection coverage.

“Covered Person” includes anyone on whose behalf the plan pays or provides any benefits, including, but not limited to, the Spouse, child or other dependent, or representative of a plan participant or person entitled to receive any benefits from the plan, including an administrator of an estate.

Subrogation and Right of Recovery

The plan has a responsibility to carefully administer claims for healthcare expenses that result from accidents or injuries for which an outside party is responsible as the primary payor or to reimburse the plan. Examples of these types of accidents include motor vehicle accidents, animal bites, business or premise liability (slip & falls), defective product or equipment, and workers compensation. The plan may need additional information from you to appropriately administer claims that contain expenses that may be the responsibility of another party.

As a condition of receiving benefits from the plan, you agree to the following provisions:

Advanced Payments

Benefits paid by the plan may be considered to be benefits advanced by the plan.

Subrogation

Immediately or upon paying or providing any benefit under the plan, the plan will be subrogated to (stand in the place of) all rights of recovery from any or all Responsible Parties, under any legal theory of any type (including equitable theories), a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to the Covered Person due to a Covered Person's injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a Covered Person receives any payment (settlement, judgment or other recovery) from any Responsible Party or Insurance Coverage as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Full Recovery Under Subrogation and Reimbursement

The plan's subrogation and reimbursement rights apply to full and partial settlements (either before or after any determination of liability), judgments or other recoveries paid or payable to the Covered Person or the Covered Person's representative, no matter how those proceeds are captioned or characterized and regardless of whether the Covered Person has been fully compensated or made whole. Payments include, but are not limited to economic, non-economic and punitive damages. No "collateral source" rule will limit the plan's subrogation and reimbursement rights. The Plan is not required to help a Covered Person to pursue his claim for damages or personal injuries, or pay any of the associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which the Responsible Party is liable. The lien is imposed on any recovery, whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits.

The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; the Responsible Party; the Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claims

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that the plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages.

The plan will be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole, or to compensate the Covered Person, in part or in whole, for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Applicability to All Settlements and Judgments

The terms of this entire Subrogation and Right of Recovery provision will apply, and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party, and regardless of whether a full or partial settlement, judgment or other recoveries paid or payable to the Covered Person or the Covered Person's legal representative identifies the medical, prescription drug or dental benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical, prescription drug and dental expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

As a condition of receiving benefits under the plan, you or your covered dependent must:

- Notify the claims administrator in writing of any claim against a third party or under an insurance policy or program, within 31 days of making the claim(s) or in compliance with the Injury Coverage Coordination process
- Complete any reimbursement agreement provided by the claims administrator
- Notify the third party and/or the issuer of the insurance policy or program that the Delta medical plan has a lien on any amounts payable by such third party and/or under the insurance policy or program to the extent covered expenses are paid by the Delta medical plan; and
- Provide any information about the claim to the claims administrator on request
- Make court appearances
- Obtain the plan's consent or its agents' consent before releasing any party from liability or payment
- Notify the plan immediately of any settlement reached
- Forward any recovery to the Plan within ten days of disbursement by the third party or notify the plan as to why you are unable to do so
- Agree to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including, but not limited to the plan's attorneys' fees, costs or damages.

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If a Covered Person fails to complete any of the steps listed here, the Covered Person will not be eligible for benefits from the plan with respect to any covered expenses attributable, directly or indirectly, to the injury, illness or condition that is, or could be, the subject of a claim against the responsible party or under an insurance policy or program.

The plan is not responsible for paying any expenses the Covered Person incurs while pursuing a claim, including legal fees and costs, unless the applicable claims administrator has agreed, in writing, and in advance, to pay those expenses.

A Covered Person will do nothing to prejudice the plan's subrogation or recovery interest, or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from taking any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify a Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of the plan's Subrogation and Right of Recovery provisions are ambiguous, or questions arise concerning the meaning or intent of any of its terms, the plan administrator for the plan will have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting benefits, the Covered Person submits to such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

MEDICAL BENEFITS

MEDICAL BENEFITS

Your health is important to you, and it's important to Delta. That's why Delta offers you competitive, comprehensive medical benefits. Without adequate medical coverage, the financial impact of a serious illness or injury can be devastating. To protect your health — and your wallet — Delta's medical coverage is designed to help make a major illness or injury easier to handle economically and to provide financial protection for minor medical problems. In addition, Delta's medical coverage encourages regular Preventive Care by covering services such as annual physicals, mammograms, well baby care and much more.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

Medical Options

In this section, you can find detailed coverage information on these medical plans, administered by UnitedHealthcare (UHC):

- Delta Account-Based Healthcare Plan (DABHP) options for active and inactive employees and their survivors
 - Health Reimbursement Account (HRA) Medical Option
 - Out-of-Area (OOA) HRA Medical Option, if eligible (only option for certain inactive employees under age 65 with Medicare primary coverage) (see callout box below)
 - Gold Health Savings Account (HSA) Medical Option
 - Silver HSA Medical Option
 - Bronze HSA Medical Option
 - OOA Gold HSA Medical Option, if eligible (see callout box below)
 - Puerto Rico OOA Medical Option (see callout box below)
- DABHP options for pre-65 retirees and their survivors (until age 65)
 - Retiree & Survivor Bronze HSA Medical Option
 - Retiree & Survivor Bronze OOA HSA Medical Option (see callout box below)

Out-of-Area Medical Options

The out-of-area options are only available to employees who live outside a UHC network area. Additionally, if you are under age 65 and have Medicare as your primary coverage, your coverage will change automatically to the Out-of-Area HRA Medical Option or the Retiree & Survivor Bronze OOA HSA Medical Option if you are a retiree or a survivor of a retiree, when Delta is notified of your Medicare enrollment. If you or your Spouse enroll in Medicare earlier than age 65, you must report this change to the ESC within 60 days of enrollment. (See "When You or Your Spouse Become Eligible for Medicare" in the "Coordination of Benefits; Subrogation and Right of Recovery Terms" section of this handbook for more information.)

You also can find information in this handbook on Health Plan Hawaii and Humana Health Plan of Puerto Rico, which are not Delta-provided coverage. Health Plan Hawaii is a fully insured medical option that is offered by Hawaii Medical Service Association (HMSA) and available to eligible individuals who reside and/or work in Hawaii. It is the state-approved Hawaii "pre-paid" medical option. Humana Health Plan of Puerto Rico is a fully-insured medical option that is available to eligible individuals who are residents of Puerto Rico.

The medical plans described in this handbook offer a variety of approaches for you to manage your healthcare. For the most part, these are very different types of plans. Plus, the differences extend further in the DABHP, depending on how you would like to fund your healthcare. To learn which medical plans and options are right for you, you should carefully read this section and consider your choices.

For each plan, a summary appears below. A full description of Covered Services appears later in this "Medical Benefits" section of the handbook.

Delta Account-Based Healthcare Plan (DABHP)

The DABHP provides you with several healthcare options. The DABHP Medical Options, administered by UnitedHealthcare (UHC), all include prescription drug coverage.

The HRA and HSA Medical Options are "account-based" and empower you to make your own healthcare decisions by enabling you to spend your healthcare dollars as you see fit. These options offer comprehensive medical coverage combined with an account that may be used to help pay eligible medical expenses.

Active employees can choose from a medical option with a Health Reimbursement Account (HRA) as part of the medical option, or a medical option that provides you access to a Health Savings Account (HSA) that you open and own separately from the medical option. Retirees and their survivors are offered only an HSA Medical Option. See "How the HRA Medical Options Work" and "How the HSA Medical Options Work" later in this "Medical Benefits" section for details on how HRAs and HSAs are funded.

Out-of-pocket protection is included in these medical plan options for years that you have high costs. But in healthy years when you have few costs, you may have account balances to roll over for use during future years.

You save money if you use Network Providers and services. If you live in an area not served by the UHC network or if Medicare is your primary coverage, you may enroll in the OOA HRA Medical Option or the Retiree & Survivor Bronze OOA HSA Medical Option (for pre-65 Delta retirees and their survivors until age 65). There are no Copayments for covered medical services, referrals are not required and Preventive Care is covered at 100% (if the care meets certain criteria explained in detail later in this "Medical Benefits" section).

Health Maintenance Organizations (HMOs)

Health Plan Hawaii, provided by Hawaii Medical Service Association (HMSA), is offered as a medical option to eligible individuals who reside and/or work in Hawaii and serves as the state-approved "pre-paid" plan. Humana Health Plan of Puerto Rico is offered as a medical option to eligible individuals who are residents of Puerto Rico.

These HMO options are not sponsored by Delta. Instead, they are managed care health maintenance organizations (HMOs) that offer eligible Hawaii and Puerto Rico residents an option that focuses on Preventive Care.

For benefits to be payable, participants must receive non-Emergency care from a provider within the HMO. Participants also must coordinate all care through a Primary Care Physician (PCP) and obtain referrals to specialists.

Note that Delta has neither control over nor responsibility for the quality of HMO services rendered to members, for failure to deliver such services, for HMO providers, or for any disputes that may arise between members and their HMO. All HMO service-related complaints and appeals of denied benefit claims must be filed directly with the HMO, not with Delta. Delta has no input or responsibility for any benefits denied by an HMO. By providing this information, Delta is not endorsing any HMO product.

Your Eligibility for Delta's Medical Plans

The DABHP is available to all benefits-eligible employees, retirees and survivors. See the "Eligibility" section of this handbook for details about the plan eligibility requirements.

Electing Coverage

Coverage Tiers

If you enroll in one of the medical options offered by Delta and are an active or inactive employee, you can choose from four coverage tiers:

Coverage Tier	Who's Covered
Employee Only	Yourself only
Employee & Spouse	You and your Spouse
Employee & Child(ren)	You and your eligible child(ren)
Family	You, your Spouse, and one or more eligible children

The coverage tier you elect for medical benefits does not have to be the same as for your dental and vision plan elections. For example, you may elect family medical coverage and employee only dental coverage. However, if you choose to enroll dependents in medical, dental and/or vision coverage, you

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must select the same healthcare option for yourself and your dependents. For example, you may not select the Gold HSA Medical Option for yourself and the Bronze HSA Medical Option for your dependents.

You also may waive medical coverage for yourself and your dependents.

Retirees and survivors do not elect healthcare benefits by coverage tier, but instead elect coverage for each eligible individual independently (yourself, your Spouse and your eligible children).

Waiving Coverage

You have the option of selecting the "No Coverage" medical option. If you waive medical coverage during the annual open enrollment period, it is important to understand the following:

If You Are Eligible As ...	And You Choose the "No Coverage" Option ...
An active employee	You waive medical coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot obtain coverage for the calendar year unless: <ul style="list-style-type: none"> • You or your dependent experience certain special enrollment events (see the "Life Events" section of this handbook) • You retire from Delta and qualify for retiree healthcare benefits, or • You die and your survivors are eligible for survivor healthcare benefits (see the "Eligibility" section of this handbook)
An active employee who becomes disabled or inactive An inactive or disabled employee	You cannot enroll in medical coverage until you return to active pay status, unless you or your dependent experience an eligible special enrollment event (see the "Life Events" section of this handbook)
An active employee who retires during the year	You may enroll for medical coverage at the time of your retirement and during future annual retiree open enrollment periods if you qualify for retiree healthcare benefits upon retirement (see the "Eligibility" section of this handbook)
An active, inactive or retired employee, and you die	Your eligible survivors may enroll for coverage at the time of your death and during future annual open enrollment periods as long as they remain eligible (see the "Eligibility" section of this handbook for survivor healthcare eligibility rules)
A retired participant	You waive medical coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot obtain coverage for the calendar year unless you or your dependent experience certain special enrollment events (see the "Life Events" section of this handbook) or you die and your survivors are eligible for survivor healthcare benefits (see the "Eligibility" section of this handbook for survivor healthcare eligibility rules)
A survivor eligible for Delta healthcare benefits	You waive medical coverage for the entire year
A COBRA participant	You waive your right to elect Delta medical coverage forever

Network and Non-Network Coverage Choices

Most Delta medical plans are network-based benefit options. They have network benefit coverage and non-network benefit coverage. In exchange for being a member of the UHC network, providers have agreed to contracted rates on their services, saving both you and Delta money. UHC offers an expansive network of doctors and health care professionals including clinics, labs and care centers, hospitals and pharmacies. Providers who are not part of the network (Non-Network Providers) have not agreed to contracted rates.

You pay less if you receive services from a Network Provider. If you see a Non-Network Provider for Covered Services instead of a Network Provider, the benefit paid by the plan is lower, and the amount you are responsible for is higher. The decision to use a Network Provider or a Non-Network Provider is always yours ... each time you need medical care.

Obtaining Discounted Services Out-Of-Area

The out-of-area medical options do not have network and non-network coverage because there is generally not a sufficient number of UHC Network Providers in locations where these options are offered. Instead, these medical options offer a uniform level of coverage. **However, there may be a few UHC Network Providers in your area who offer contracted rates on their services to UHC members, in which you can still benefit.**

Call the number on the back of your UHC ID card or visit **myuhc.com** to confirm whether a doctor or hospital is in the network — or simply ask your doctor. You may receive a list of Network Providers at no charge by contacting Delta Health Direct at **877-912-1820** or by going online to **myuhc.com** to print one.

Network Benefits – UHC Choice Plus

When you are enrolled in a network option (HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA) and use doctors, hospitals and other medical providers who are part of UHC's Choice Plus Network, network benefits apply. "Network benefits" mean that Covered Services are paid at a higher percentage after the annual Deductible. Another advantage to using Network Providers is that they usually handle any pretreatment approval when it is needed.

Reasons to Use Network Doctors

Save Money on Your Office Visits: You receive a contracted rate if you visit doctors and hospitals in the network. For example, while a non-network doctor may charge \$85 for an office visit, a network doctor may charge a contracted rate of \$65 for the same service.

Convenient Claims Submission: Network doctors submit claims on your behalf. Non-network doctors may or may not offer this convenience.

Access to Premium Providers: UnitedHealth Premium program evaluates doctors for quality of care and cost efficiency. The Premium designation helps you find doctors who meet national standards for quality and local market benchmarks for cost efficiency.

Allowed Amount

Network Providers have agreed to accept certain predetermined contracted fees as payment in full. This is known as the "Allowed Amount." More specifically, the Allowed Amount is defined as the negotiated amount of payment that a Network Provider has agreed to accept as payment in full for a Covered Service at the time your claim is processed.

Network benefit payments are based on UHC's Allowed Amount for medical expenses. When you use Network Providers, you only have to pay the Deductible and any Coinsurance amounts. With Network Providers, you are not responsible for any charges over the Allowed Amount.

If you receive Covered Services from a Non-Network Provider that are:

- Coordinated in advance by UHC,
- As a result of an Emergency, or
- For radiology, anesthesiology, pathology, lab or assistant surgeons and your Network Provider bills for them,

then, the Allowed Amount is an amount determined by UnitedHealthcare (that may be lower than the provider's billed charges), unless a lower amount is negotiated or authorized by law. In this case, the Non-Network Provider **should not**, but may, bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens, contact Delta Health Direct at **877-912-1820**.

Find a Network Doctor, Hospital or Other Healthcare Professional on **myuhc.com**

- Find and compare network doctors and hospitals
- Save time with a list of the most commonly searched topics or find a doctor based on location, specialty, condition or procedure
- Search and compare hospitals on quality and cost of care for specific treatments
- Identify UnitedHealth Premium® designated network physicians who are recognized for high quality and efficiency of care

Step 1: Log on to **myuhc.com**

Step 2: Click the "Find a Doctor" button, or select "Find Care & Costs" from the menu bar

Step 3: Begin a medical, mental health or pharmacy directory search

Step 4: Follow the directions to search by people, places, services and treatments, care by condition or to access cost estimates

To search without logging in, go to **myuhc.com** and click on "Find Medical and Mental Health Providers and Facilities" under "Links and Tools". You also can call the number on the back of your UHC ID card. You also can receive a list of Network Providers at no charge by contacting Delta Health Direct at **877-912-1820**.

Non-Network Benefits

When you are enrolled in a network option and use doctors, hospitals and other medical providers who are not part of the UHC Choice Plus Network, non-network benefits apply. Non-network benefits pay a lower amount of the provider's submitted charges and you will be required to pay more out of pocket in most cases. You may check a provider's status in your area by visiting **myuhc.com** or by calling the "For Members" number on the back of your ID card.

You are responsible for filing claims or seeing that claims have been filed by your provider. You also are responsible for calling for pre-approval of certain outpatient services, for hospital pre-approval and for continued stay approval when necessary.

In addition, you generally pay more for a medical service when using a Non-Network Provider because he or she has not joined the network and therefore has not agreed to accept contracted fees. You are responsible for any amount over the "Eligible Expenses," which are determined by the claims administrator.

Gap Exception for Non-Network Providers

If you are enrolled in a network option, and you need to see a provider within a certain specialty but there is no Network Provider and/or facility within a 30-mile radius of your home ZIP Code, you may be eligible to receive benefits for certain Covered Services by a Non-Network Provider within that specialty at the network level. All benefits that fall under this category must be approved prior to receipt of care and are subject to any plan limitations or exclusions set forth in this handbook. *You must call Delta Health Direct at 877-912-1820 to obtain such approval.*

Eligible Expenses for Non-Network Benefits

UHC, as the claims administrator, has the discretion and authority to decide whether a treatment or supply is a Covered Service and how the Eligible Expenses will be determined and otherwise covered under the HRA, Gold HSA, Silver HSA, Bronze HSA and Retiree & Survivor Bronze HSA Medical Options. For these options, UHC determines Eligible Expenses primarily using the Maximum Non-Network Reimbursement Program (MNRP). Under the MNRP, Non-Network Charges are based on a percentage of the federal Medicare-allowable charge for the applicable types of medical services and supplies. A Medicare-allowable charge is what the federal Medicare program would allow as a covered expense.

Below is a summary of how UHC determines Eligible Expenses for non-network benefits:

- A negotiated rate for the service or supply may be agreed to between UHC and the Non-Network Provider. This negotiated rate is the Eligible Expense
- If rates are not negotiated between UHC and the Non-Network Provider, then one of the following amounts is the Eligible Expense:
 - Under the DABHP network medical options, the Eligible Expenses for non-network services and supplies are based on 140% of the Medicare-allowable charge (published rates allowed by the Centers for Medicare and Medicaid Services (CMS)) for the same or similar service or supply within the geographic market. This is referred to as the MNRP fee limit. MNRP applies to most non-network medical services and supplies including hospital, physician, radiology and medical supply expenses, and other non-network expenses for Covered Services. (Note: Emergency care, certain services billed by a Network Provider (such as radiology and lab fees) or services

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coordinated in advance by UHC are paid as network benefits; see “Allowed Amount” under the “Network Benefits– UHC Choice Plus” section above)

- If there is not an established Medicare-allowable charge, UHC uses an available “gap methodology” to determine a rate for the service as follows:
 - > For services other than Pharmaceutical Products*, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. Refer to UHC’s website at **myuhc.com** for information regarding the vendor that provides the applicable relative value scale information
 - > For Pharmaceutical Products*, UHC uses gap methodologies that are similar to the pricing methodology used by Medicare, and produces fees based on published acquisition costs or average wholesale price of the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UHC based on an internally developed pharmaceutical pricing resource
- If an MNRP rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 60% of the provider’s billed charge

UHC typically updates the CMS published rates within 30 to 90 days after updated CMS data becomes available.

You, as the covered participant, are required to pay 100% of the amount billed to you by the provider that is in excess of the Eligible Expense, because that excess amount is not covered by the plan. Only the amount you pay that is determined to be an Eligible Expense will be applied to your Deductible. Any charges in excess of Eligible Expenses are not covered by the plan so they are not applied to your Deductible or Coinsurance amounts and, therefore, can result in much higher costs to you than you may have anticipated. You are responsible for paying, directly to the Non-Network Provider, any difference between the amount the Non-Network Provider bills you and the amount UHC pays for Eligible Expenses.

Out-of-Area Benefits

When you are enrolled in an Out-of-Area Medical Option and receive Covered Services from a Non-Network Provider, the benefit level paid by the plan is the same as the benefit level for a Network Provider. However, Eligible Expenses for out-of-area benefits are calculated differently, and you may have higher out-of-pocket costs because Non-Network Providers have not agreed to accept contracted rates. You are responsible for any amount over Eligible Expenses, which are determined by the claims administrator.

You are also responsible for filing claims or seeing that claims have been filed by your provider. You also are responsible for calling for pre-approval of certain outpatient services, for hospital pre-approval and for continued stay approval when necessary.

Eligible Expenses for Out-of-Area Benefits

UHC, as the claims administrator, has the discretion and authority to decide whether a treatment or supply is a Covered Service and how the Eligible Expenses will be determined and otherwise covered under the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA and Puerto Rico OOA Medical Options. For these options, UHC determines Eligible Expenses primarily using the Reasonable and

* Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Service by a physician or other health care provider within the scope of the provider’s license, and not otherwise excluded under the plan.

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Customary (R&C) methodology. Under the R&C methodology, these benefit payments are based on a percentage of the R&C charge for a medical expense.

Below is a summary of how UHC determines Eligible Expenses for out-of-area benefits:

- A negotiated rate for the service or supply may be agreed to between UHC and the provider. This negotiated rate is the Eligible Expense
- If rates are not negotiated between UHC and the provider, then one of the following amounts is the Eligible Expense:
 - For services or supplies other than Pharmaceutical Products*, the Eligible Expenses are based on R&C charges, which UHC determines based on data resources of competitive fees in a geographic area. (Note: Emergency care or services coordinated in advance by UHC are paid as network benefits; see "Allowed Amount" under the "Network Benefits– UHC Choice Plus" section above)
 - For Pharmaceutical Products*, Eligible Expenses are based on 110% of the published rates for the federal Medicare-allowable charge for the item. A Medicare-allowable charge is what the federal Medicare program would allow as a covered expense for the same or similar service within a geographic market. If there is not an established Medicare-allowable charge, UHC will use "gap methodologies" that are similar to the pricing methodology used by Medicare and produce fees based on published acquisition costs or average wholesale price of the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomas Reuters* (published in its Red Book) or UHC based on internally developed pharmaceutical pricing resources

You, as the covered participant, are required to pay 100% of the amount billed to you by the provider that is in excess of the Eligible Expense, because that excess amount is not covered by the plan. Only the amount that you pay that is determined to be an Eligible Expense will be applied to your Deductible. Any charges in excess of Eligible Expenses are not covered by the plan so they are not applied to your Deductible or Out-of-Pocket Maximum and, therefore, can result in much higher costs to you than you may have anticipated. You are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount UHC pays for Eligible Expenses.

* Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Service by a physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the plan.

Multiple Procedure Payment Reduction

Many medical and surgical services include pre-procedure and post-procedure work, as well as generic services integral to the standard medical/surgical service (for example, draping the patient, inserting a venous access device, and recording preoperative, intraoperative and postoperative documentation). When multiple procedures are performed on the same day, by the same group physician and/or other health care professional, reduction in reimbursement for secondary and subsequent procedures will occur. Full allowance for secondary and subsequent procedures would represent reimbursement for duplicative components of the primary procedure.

UHC reduces the Allowed Amount or Eligible Expense for secondary and all subsequent surgical procedures as well as specific secondary services rendered in a single course of care to account for duplicative components. These secondary procedures are related to the following services:

- Endoscopies
- Radiology interpretations
- Technical portion of certain diagnostic cardiology and ophthalmology services including operating room access, payments made for the paper covering that the patient lies on in the operating room, the syringe used to inject anesthesia and the insertion of a scope when the instrument is used to examine multiple internal areas

Since providers will receive lower reimbursement for secondary and subsequent procedures and services, you may see a reduction in out-of-pocket costs too, particularly if undergoing endoscopy procedures. In this case, your explanation of benefits remark code will state that UHC has applied the maximum amount allowed for this service. It will indicate that the service has been reduced based on the Multiple Procedure Payment Reduction Reimbursement Policy.

You may only be negatively affected if you use a Non-Network Provider. Therefore, you are encouraged to use Network Providers for the best cost savings. If you use a Non-Network provider for a procedure or service where this multiple procedure payment reduction applies, you may be balance billed by your provider.

Medical Plan Features

When You Must Obtain Prior Authorization from UHC or OptumHealth Behavioral Solutions

UnitedHealthcare (UHC) and OptumHealth Behavioral Solutions require Prior Authorization for certain Covered Services. Prior Authorization allows for a thorough review to ensure that the proposed service is a Medically Necessary Covered Service. A list of the Covered Services that require Prior Authorization can be found on the next few pages.

Prior Authorization Process

In general, physicians and other health care professionals who participate in the network are responsible for obtaining Prior Authorization. However, you are responsible for obtaining Prior Authorization before you receive such services if you choose to receive Covered Services from a Non-Network Provider, or if you participate in the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or Puerto Rico OOA Medical Option.

Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

It is recommended that you confirm with UHC that the Covered Services listed below have been approved as a Medically Necessary Covered Service and that required Prior Authorization has been provided to the provider/facility. Before receiving these services from a Network Provider, you may also want to contact UHC to verify that the hospital, physician and other providers are Network Providers and that they have obtained the required Prior Authorization.

Please note that if you choose to receive a service that has been determined not to be a Medically Necessary Covered Service, that service is not covered by the Plan and you will be responsible for paying all associated charges.

How to Obtain Prior Authorization

If you receive care through a Network Provider, the Network Provider should obtain Prior Authorization for you. If you are using a Non-Network Provider, or if you participate in the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA, or Puerto Rico OOA Medical Option, **you** are responsible for obtaining Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** (or having your doctor do so). For behavioral health services and substance use treatment that requires Prior Authorization, your doctor should notify OptumHealth Behavioral Solutions directly at **800-533-6939**.

Services or Supplies Requiring Prior Authorization

You or your physician or other healthcare provider must obtain Prior Authorization from UHC before receiving the following services or supplies. Your physician must call OptumHealth Behavioral Solutions for behavioral health services and substance use treatment requiring prior authorization before receiving those services. Be sure to read "What the Delta Medical Plans Cover" later in this "Medical Benefits" section for full coverage details about these services and supplies.

- Ambulance – non-Emergency air
- Bariatric surgery (covered at Centers of Excellence only)
- Breast cancer susceptibility test (BRCA 1 and BRCA 2)
- Congenital heart disease surgeries

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- Durable medical equipment when cost exceeds \$1,000 to purchase or rent
- Home healthcare
- Hospice care - inpatient
- Hospital inpatient stay – all elective (non-Emergency) admissions
- Inpatient hospital care (for mother and child) following childbirth that exceeds 48 hours (or 96 hours if a cesarean section)
- Lab, X-ray and diagnostics – outpatient sleep studies and major diagnostics including CT scans, PET scans, MRI, MRA and nuclear medicine including diagnostic catheterization and electrophysiology implants
- Mental health services, neurobiological disorder services (Autism Spectrum Disorder services) and/or substance use disorder services as follows:
 - A scheduled in-patient admission (for emergency admissions, see “When to Notify Delta Health Direct (Prior Authorization Not Required)” on the next page)
 - Partial hospitalization/day treatment and services at a residential treatment facility
 - Intensive outpatient program treatment
 - Outpatient electro-convulsive treatment
 - Extended outpatient treatment visits beyond 45 – 50 minutes in duration, with or without medication management
 - Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA)

Note that Prior Authorization from OptumHealth Behavioral Solutions for outpatient treatment (other than those listed above), is generally not required; however, you are strongly encouraged to notify OptumHealth Behavioral Solutions for those outpatient services prior to receiving care.
- Organ transplant services (covered at UHC’s Transplant Centers of Excellence only)
- Prosthetic devices when cost exceeds \$1,000 to purchase or rent
- Qualifying clinical trials
- Reconstructive procedures, including breast reconstructive surgery following mastectomy and breast reduction surgery (not covered when considered cosmetic)
- Skilled nursing facility/inpatient rehabilitation facility services
- Surgery:
 - When inpatient hospital stay is required
 - For the following outpatient surgeries: arthroscopy, hysterectomy, sinuplasty, cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implants, sleep apnea surgeries, orthognathic surgeries, and for selected infusions of anti-inflammatory/immune modulator medications covered under the medical benefit when administered in an outpatient hospital setting
- Therapeutic Treatments – all outpatient therapeutics (except for dialysis)

When Prior Authorization Must Be Obtained for Hospital (Inpatient and Outpatient) Services

- For elective (non-emergency) hospital admissions, at least five days before the scheduled admission date
- For outpatient services, at least five days before the scheduled service date
- For maternity inpatient confinement related to delivery of child (for either the mother or the child) that continues beyond the 48- to 96-hour limits

Delta Health Direct must be contacted for Prior Authorization only if the inpatient care for the mother or child is expected to continue beyond 48 hours following vaginal delivery or 96 hours following a cesarean section. Under federal law, you do not have to get pre-approval for a maternity admission if your expected hospital stay is 48 hours or fewer for a normal delivery, or 96 hours or fewer for a cesarean section. See the "Plan Administration and Legal Rights" section of this handbook for details

- Non-Emergency maternity inpatient confinement without delivery of child
 - Confinement during pregnancy, but before the admission for delivery, that is not Emergency Care requires Prior Authorization as a scheduled inpatient admission

When to Notify Delta Health Direct (Prior Authorization Not Required)

- For Emergency admissions (also termed non-elective admissions), Notification should happen as soon as reasonably possible. If you are admitted to a non-network hospital as a result of an Emergency, Notification is required within two business days of admission or on the same day of admission, if reasonably possible. If UHC is not notified within the timeframe noted, the charges will not be covered under the Plan.
- For prenatal programs, Delta Health Direct should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in the prenatal programs. And, be sure to enroll in the Maternity Support Program (described later in this section).

Information to Provide During Prior Authorization

The following information must be provided during Prior Authorization:

- The name of the patient and his or her relationship to you
- The employee's name, employee number and address
- The employer's name
- The name and telephone number of the attending physician
- The name of the medical care facility, proposed date of admission and proposed length of stay
- The diagnosis
- Type of surgery and proposed course of treatment
- The proposed rendering of listed medical services

While your doctor or the facility may call on your behalf, you are responsible for the call being made on time. Make sure your doctor, family members and anyone else who might have to call for you know about the Prior Authorization requirement and where you keep your medical ID card.

Once the call has been made, UHC contacts your doctor to discuss symptoms, test results, the treatment plan and the length of stay. After your doctor provides the necessary medical information, UHC reviews the case to determine if it is a Medically Necessary Covered Service. When the Prior Authorization review is complete, you may receive a phone call from UHC. You, your doctor and the hospital also are notified by letter. Please note that if you choose to receive a service that has been determined not to be a Medically Necessary Covered Service, the service is not covered under the Plan and you will be responsible for paying all associated charges.

Notifying UHC/OptumHealth Behavioral Solutions

You or your doctor should call Delta Health Direct at **877-912-1820** to obtain Prior Authorization from UHC for certain services as described earlier. For the behavioral health services and substance use treatment services described earlier, your doctor should call OptumHealth Behavioral Solutions directly at **800-533-6939** to obtain Prior Authorization.

If you receive care through a Network Provider, your Network Provider should handle obtaining the Prior Authorization for you. However, *you* are responsible for obtaining Prior Authorization before you receive such services if you choose to receive Covered Services from a Non-Network Provider, or if you participate in the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or Puerto Rico OOA Medical Option.

If you do not receive this Prior Authorization or if the service is not authorized, the service will not be covered under the Plan and you will pay all associated charges.

No Pre-Existing Condition Limitations

Generally, a Pre-Existing Condition is a physical or mental condition that you or an eligible dependent received treatment for, or was diagnosed with, before coverage under a plan began. The Delta medical plans cover eligible expenses for a Pre-Existing Condition the same as for any other medical condition.

Lifetime Maximum Medical Benefit

There are no lifetime maximum benefits for the medical options under any of the Delta healthcare plans.

ID Cards

Using and referring to your member identification (ID) card is key when you need to receive care and ensure that you are not billed unnecessarily. You and your covered family members should carry the medical ID card with you at all times, and present it whenever you receive services from a doctor or other healthcare professional.

DABHP Participants

If you enroll in a Delta medical option with UHC network and non-network coverage, you receive medical ID cards for yourself and your covered dependents. Present your ID card whenever you receive services, including pharmacy benefits.

If you enroll in an out-of-area medical option, you receive two UHC ID cards in your name (the employee). If you need additional cards, contact Delta Health Direct at **877-912-1820** or place your order online at **myuhc.com**.

You should report lost or stolen ID cards to UHC.

Need a temporary ID card or a replacement card?

Step 1: Log on to **myuhc.com**

Step 2: Click the "View & Print Member ID Cards" box

Step 3: Click "Print ID Card" to print a temporary card, *or*

Step 4: Click "Mail ID Card" to request a replacement card by mail. Your new UHC medical ID card will be mailed to the address on file with the ESC

Health Plan Hawaii Participants and Humana Health Plan of Puerto Rico Participants

If you enroll in Health Plan Hawaii or Humana Health Plan of Puerto Rico, you receive ID cards for yourself and your covered dependents. Present your ID card whenever you receive any medical or pharmacy service.

If you have questions or to report a lost or stolen ID card, contact

- Health Plan Hawaii at **808-948-6372** or visit Health Plan Hawaii at **www.hmsa.com**, or
- Humana Health Plan of Puerto Rico at **787-282-7900 ext. 5500** or visit Humana at **www.humana.com**

Care Away From Home

UHC has participating providers throughout the country. If you or a covered dependent is away from home and in a UHC Choice Plus Network area, you may seek care from participating providers anywhere in the country and receive network benefits. This is called reciprocity.

For a list of UHC Network Providers in any area, call Delta Health Direct at **877-912-1820**. You also may access the UHC provider directory at **myuhc.com**. Reciprocity may be beneficial for you if:

- You travel throughout the United States extensively
- For part of the year, you live in another area served by the UHC Choice Plus Network
- Your child(ren) attend school in another area served by the UHC Choice Plus Network
- Your child(ren) and/or Spouse live in another area served by the UHC Choice Plus Network

Are You Covered Outside of the United States?

You and your eligible family members have medical coverage worldwide. If you receive care while outside of the United States, contact UHC at **877-564-7510**. Unless the treatment is for a medical Emergency, non-network provisions apply. You are responsible for submitting claims and providing the necessary documentation, which should include an explanation (in English) detailing the medical condition and treatment provided. Additionally, the itemized list of the charges should be documented in U.S. currency.

Claims, Appeals and Legal Actions

You have many rights regarding denied claims and the appeal of denied claims. These are covered in the "Claims Information & Appeals" section of this handbook. With respect to any legal action against the Plan, you cannot bring such action until 90 days after you have properly submitted a claim and all required reviews of your claims have been completed. See the "Claims Information & Appeals" section for more details. In no event may you bring any legal action or proceeding for benefits under the Delta Account Based Healthcare Plan later than one year following the date on which you have exhausted all administrative remedies available to you under the Plan.

Find the Answers You Need

Call the ESC at 1-800 MY DELTA (1-800-693-3582) for ...

- General information about medical coverage
- Technical and navigational support for the Benefits Direct website, including the Health Plan Evaluator Tool
- Plan Premiums
- Corrections to your employee information (such as birth date or Social Security number)
- Enrollment process, including enrollment dates, plan eligibility, etc. (for actives, inactive, retirees and survivors)
- Non-medical benefit enrollment or general information (dental, vision, disability, optional insurances)
- Life event changes (such as marriage, divorce or birth of a child)
- Requests for hard copies of handbooks/summary plan descriptions (SPDs)/benefit coverage documents
- Verification of dependent eligibility related to age or status
- COBRA enrollment questions

Call Delta Health Direct at 877-912-1820 for any of the following ...

- Medical plan coverage information and questions
- How the benefits work, including pharmacy
- Which providers and services are network and non-network
- Network Provider search
- Claims
- Healthcare Flexible Spending Account (FSA) — Full Purpose and Limited Purpose
- Replacement medical ID cards
- Member complaints/appeals
- Coordination of benefits
- Network questions
- Transition of care

Other Important Health Management Support Phone Numbers

Employee Assistance Program (offered by OptumHealth Behavioral Solutions)*	800-533-6939
Cleveland Clinic's MyConsult [®] Online Medical Second Opinion*	800-223-2273, ext.43223

* Note: These numbers enable you to reach the programs directly, but you also can access any of these numbers by calling Delta Health Direct.

Medical Plan Programs

Delta Health Direct

In any household on any given day, a health question comes up. How to treat a minor injury? Where to go for care? How to quit smoking safely and effectively? When to ask for help, whether it's a chronic condition, emotional health, or affording a prescription? **Now you can call one number and get the answers you need.**

Delta Health Direct is a "concierge" health program that provides access to services you are used to, including NurseLine, Wellness Coaching and Benefits & Claims Advocacy. In addition, the concierge component will allow you and your dependents to call and receive information about premium Network Providers in your area as well as assistance in scheduling appointments.

The Delta Health Direct team for Delta members is administered and staffed by UHC and provides Delta families with 24/7 access to a one-stop shop for health management needs. The Delta Health Direct team is comprised of registered nurses, wellness coaches and health specialists that will help Delta families manage a variety of health care needs such as complex conditions, questions about new medications, finding physicians and scheduling appointments, and improving the quality of life with support in tobacco cessation, weight management and more.

You can call Delta Health Direct for any health management related need or question. You can even call before a health need arises and a Delta Health Direct nurse will help you get the answers and the support when you need it.

The experienced Delta Health Direct registered nurses can help you:

- Recognize symptoms and choose the most appropriate setting for care
- Learn effective self-care techniques for minor illnesses and injuries
- Understand treatment options for diagnosed conditions
- Find a new doctor or specialist and schedule an appointment
- Get the resources and coaching you need to quit smoking, lose weight, deal with stress and more
- Get you connected to the right health management resources as part of your UHC benefits

If you are living with a chronic condition or dealing with complex health care needs, specialized Delta Health Direct nurses can help answer questions, explain options, identify your needs and be with you every step of the way. They can help prepare you for an upcoming hospital stay, work with your doctor while you are hospitalized, and help get you what you need for a successful recovery after your stay.

To reach the Delta Health Direct team for confidential assistance with any health need or question, call **877-912-1820**, 24 hours a day, seven days a week. Or, you can send an email to deltahealthdirect@uhc.com.

The programs found on the next few pages are included in your Delta healthcare benefits and there is no extra cost to you to participate. The nurses you will speak with are supported by a team of physicians and have access to the latest medical tools and resources available, so you know that you are getting information that you can trust.

If you believe you are having a life-threatening medical Emergency, dial 911.

Bariatric Resource Services

Facility and surgeon charges for weight loss surgery are covered under the DABHP Medical Options for those who meet eligibility requirements. As part of this benefit, you have access to Bariatric Resource Services (BRS) and to case managers who will assist with assessment and preparation for surgery, surgical intervention and treatment, and post-surgical management to minimize the potential long- and short-term complications associated with bariatric surgery. Since the clinical outcomes of bariatric surgery also vary widely, case managers will assist you in selecting a facility from the BRS Centers of Excellence.

Call Delta Health Direct at **877-912-1820** or visit **myoptumhealthcomplexmedical.com** for more information.

Cancer Support

Coping with an advanced illness like cancer can be a challenge for both patients and their families. If you have been touched by cancer, Delta Health Direct nurses can find providers who specialize in cancer support and can help you and your loved ones answer questions and make difficult decisions, at no cost. Cancer Support covers all types of cancer and gives you and your family a single source for personal support through an experienced cancer nurse who can help you understand your diagnosis and potential treatment options, as well as provide you with information to help you maintain your health and well-being during treatment and recovery.

As part of the Advanced Illness Support Program, Delta Health Direct nurses can arrange for a nurse who specializes in advanced illness to meet with you and your family. This program is a supplement designed to enhance – not replace – other treatment and counseling programs already available through Delta's medical options.

Cancer support is also available to you or your covered dependents as part of the Delta Health Direct program and gives you access to United Health Premium Network cancer programs and facilities. If you have a serious medical need, specialized programs and nurse consulting are available through UHC's Cancer Centers of Excellence network programs. Please note that 100% coverage is available after the Deductible is reached and only when using a Center of Excellence. Refer to "What The Delta Medical Plans Cover" in this Medical section for further details about your benefits for cancer treatment.

For information about Cancer Support, call Delta Health Direct at **877-912-1820** or go to **myoptumhealthcomplexmedical.com**.

Chiropractic Clinical Support Program

The program provides access to a high-performing chiropractic network focused on delivering quality care and helping ensure the right care is delivered. This is achieved through utilization reviews and provider dialogue within the chiropractic community.

Kidney Resource Services

The Kidney Resource Services (KRS) provides support for those with advanced stage chronic kidney disease that are transitioning into renal replacement therapy and those on dialysis. As part of the support available, you will receive assistance selecting Network Providers, better performing dialysis centers, as well as specialty centers that meet quality of care standards.

The plan pays benefits for Comprehensive Kidney Solutions (CKS) that covers both chronic kidney diseases and end-stage renal disease (ESRD) provided by Designated Facilities participating in the KRS program. Designated Facility is defined in "Terms to Know" section at the end of this handbook.

In order to receive benefits for this support, KRS must provide the proper notification to the Network Provider providing the services. This is true even if you self-refer to a Network Provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis, and
- Prior to any ESRD services

You or a covered Dependent may:

- Be referred to KRS by a Delta Health Direct nurse by calling **877-912-1820**, or
- Call **877-912-1820** and select the Kidney Resource Services prompt

Dialysis performed at a non-network facility is not a Covered Service under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA.

To receive other benefits related to ESRD and chronic kidney disease (excluding dialysis), you may visit a non-network facility. If you receive services from a non-network facility, the plan pays benefits at the non-network level.

To receive benefits under the KRS program, you must contact KRS prior to obtaining Covered Services. The plan will only pay benefits under the KRS program if KRS provides the proper notification to the Network Provider or facility performing the services (even if you self-refer to a provider in that network). Additional information may be accessed at myoptumhealthcomplexmedical.com.

Maternity Support

If you are pregnant or thinking about becoming pregnant, you can get valuable educational information, advice and comprehensive case management by engaging with Delta Health Direct nurses specializing in the Maternity Support. UHC's Maternity Support is designed to enhance your pregnancy experience by assigning a dedicated obstetrics (OB) nurse to help you better understand your pregnancy. Your OB nurse will provide clinical and practical advice and answer your questions throughout your pregnancy.

This program applies to participants enrolled in any of the Delta healthcare plans.

To take full advantage of this support, you are encouraged to engage with a Delta Health Direct nurse within the first trimester of pregnancy. There is no cost to working with a Delta Health Direct nurse specializing in maternity support. Some of the services include:

- Pre-conception health coaching
- Toll-free information lines staffed by experienced OB nurses
- Printed and online educational resources covering a wide range of topics
- First and second trimester risk screenings

- Identification and management of at-risk or high-risk conditions that may affect pregnancy
- Pre-delivery consultation
- Coordination with and referrals to other benefits and programs available under the medical plan
- Support after your baby is born, including a phone call from a nurse approximately two weeks after your baby is born to answer your questions and give you information about newborn care, feeding, immunizations and more
- Screening for post-partum depression

To connect with a Delta Health Direct nurse specializing in maternity support, call Delta Health Direct at **877-912-1820**.

Neonatal Resource Services

Neonatal Resource Services (NRS) works in conjunction with Maternity Support to identify pregnancies that might be high risk, and to encourage delivery at a Neonatal Centers of Excellence network facility. In addition, NRS has experienced Neonatal Intensive Care Unit (NICU) nurses available to answer questions about your baby's care in the NICU and transition to home. This program gives mothers and babies the opportunity for a better outcome.

Call Delta Health Direct at **877-912-1820** or visit myoptumhealthcomplexmedical.com for more information.

Special Needs Support Program

Families of children with special needs may have uniquely complex challenges and significant health care needs. Special needs support is offered through the Plan at no additional cost through Delta Health Direct and is tailored to support Delta families by providing a single point of contact who can help in navigating the route of care. Services span across medical, behavioral and pharmacy needs, including insurance and payment, care delivery, social support, and family well-being. For additional program information or to connect with an adviser, call Delta Health Direct at **877-912-1820**.

Spine and Joint Solution (SJS) Program

The Spine and Joint Solution (SJS) Program is a surgical program that provides access to top-performing, regional surgical centers for individuals who meet the criteria for select elective, inpatient surgeries. When you contact the specialized nurse team and enroll in the SJS Program, the plan pays benefits for select elective, inpatient surgeries provided by designated facilities participating in the SJS Program. The specialized nurse team provides guided access to a network of credentialed SJS Program providers.

When a UHC Spine and Joint Center of Excellence is used, travel and lodging for the patient and one family member acting as a travel companion, up to a \$2,000 lifetime limit, is covered by the plan.

Please note that 100% coverage is available after the Deductible is reached and only when using a Center of Excellence. Refer to "What The Delta Medical Plans Cover" in this "Medical Benefits" section for further details about your benefits for spine and joint surgeries.

For information about the SJS Program, including available locations in this Center of Excellence network, call Delta Health Direct at **877-912-1820**.

Transplant and Heart Disease Support

Register with United Resource Network (URN) via the Web for transplant services or for treatment of congenital heart disease. Access the nation's leading transplant network of carefully selected transplant programs in medical centers throughout the country. If you have a serious medical need, specialized programs and nurse consulting are available to you through UHC Transplant Centers of Excellence network programs.

Step 1: Log on to **myuhc.com**

Step 2: Click on "Coverage & Benefits"

Step 3: Click on the "Centers of Excellence Network"

Step 4: Click the appropriate program link

OR

Call Delta Health Direct at **877-912-1820** or visit **myoptumhealthcomplexmedical.com** for more information.

Note: Transplant services not performed through the UHC Transplant Centers of Excellence network are not Covered Services under the plan.

Wellness Coaching

If you are thinking of breaking free from your nicotine addiction, losing weight, finding a better nutrition plan or are suffering from low back pain, specialized Delta Health Direct wellness coaches can help support your wellness needs.

To connect with a specialized Delta Health Direct wellness coach for weight management, stress management, nutrition, exercise, tobacco cessation, heart healthy living, diabetes wellness, or musculoskeletal support call **877-912-1820**.

Delta Health Direct wellness coaches specialize in low back pain and will be your one-stop shop for information, advice and encouragement. They will help you understand your treatment options, help with access to the right kind of care, and give you tips and advice on how to limit or stop low back pain. And, they will be there for you in the future if you have problems.

From **myuhc.com**, you can access all sorts of information on low back pain, take a back pain assessment, and gain access to stretching and exercise tips, information on warning signs, and a walk-through on treatment options.

Under the Delta medical plan options, you have access to the Delta Health Direct Quit for Life program, a tobacco cessation program that combines telephone coaching with appropriate nicotine replacement therapy. For information, call **877-912-1820** or the number on the back of your UHC ID card, or search for Tobacco Cessation on Deltanet.

Delta Health Rewards Program (Does Not Apply to Retiree Healthcare, COBRA or Survivor Coverage under the DABHP)

The Delta Health Rewards program is part of the Delta Account-Based Medical Plan that runs January to November of each calendar year. For more information about the Delta Health Rewards Program, including an overview brochure, a Learn More document, a Health Actions chart and other online videos and materials, refer to the Delta Health Rewards site located on Deltanet.

2019 Program (Actions Completed During the Period January 1, 2019 – November 30, 2019)

The amount of Delta Health Rewards you can earn in 2019 depends upon which medical option you choose and who you cover. If you enroll in employee only coverage or in employee plus spouse coverage in any of the account-based medical options, you can earn up to \$700 and your spouse can earn up to \$700 in Delta Health Rewards.

There is additional funding for employees who cover children in either the Gold or Silver HSA option or in the HRA option. If you cover children in the Gold or Silver HSA option or in the HRA option, you will receive \$250 deposited into your account automatically. Also, if you cover children, you can earn up to \$1,100 in Delta Health Rewards (additional \$400 over the maximum standard reward amount of \$700). Therefore, those enrolled in employee plus children coverage can receive up to \$1,350 in Delta Health Rewards and automatic child funding. If you also cover a spouse, they can earn up to \$700 themselves. So those covering a family could receive up to \$2,050 in Delta Health Rewards and child funding.

No additional child funding is earned or given if you are enrolled in the Bronze HSA. The maximum Delta Health Rewards that may be earned and received is \$1,400 if you and your spouse are enrolled in the Bronze HSA option.

In addition to the core health actions, you can participate in condition-based programs via Delta Health Direct or other available programs. Refer to the 2019 Delta Health Rewards charts on the following pages for details.

Delta Health Reward dollars are deposited to your Optum Bank HSA or HRA during the year, as the actions are completed, and all health actions or conditioned-based programs must be completed by November 30, 2019 to receive Delta Health Reward dollars associated with those actions or programs.

If you are enrolled in one of the HSA Medical Options, you must open an Optum Bank HSA account in order to receive earned Delta Health Reward dollars or child funding. You can do this directly or provide your online consent during the annual enrollment period (or at other times) to allow Delta to open an account on your behalf. If you do neither, your Delta Health Rewards dollars will not be deposited. Note: You must have a physical address on file to open an Optum Bank HSA.

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2019 Health Actions	Delta Health Rewards Dollars Earned in 2019		
	By You		By Your Spouse
	If Not Covering Children or Covering Children in the Bronze HSA	If Covering Children (HRA, Gold HSA or Silver HSA)**	
1. Complete the online Rally Health Survey on myuhc.com	\$75	\$150	\$75
2. Use the cost estimator tool on myuhc.com	\$25	\$50	\$25
3. Identify yourself as a non-tobacco user on the Rally Health Survey or submit the Provider Health Screening Form or complete the Delta Health Direct Quit for Life program*	\$100	\$200	\$100
4. Get your annual physical exam (including a well woman exam)	\$100	\$200	\$100
5. Submit biometrics and have a Body Mass Index (BMI) is less than or equal to 27.5 or a 2 point improvement (see callout below for additional information)*	\$100	\$200	\$100
6. Submit biometrics and have total cholesterol is less than 240 (see callout below for additional information)*	\$100	\$100	\$100
7. Submit biometrics and have Fasting Blood Sugar (FBS) less than 100 or A1c less than 5.7% (see callout below for additional information)*	\$100	\$100	\$100
8. Submit biometrics and have Blood Pressure less than or equal to 140/90 (both numbers must be less than or equal to) (see callout below for additional information)*	\$100	\$100	\$100
TOTAL	\$700	\$1,100	\$700
Automatic Child Funding (HRA, Gold or Silver HSA)		\$250	
<p>* Even if one or more of your biometrics are not within the healthy ranges, you have the opportunity to earn the entire \$400 in Delta Health Rewards dollars related to those biometrics by completing a Delta Health Direct telephonic wellness program (plan up to 10 weeks to complete) or three online Rally Missions (plan a minimum of four weeks to complete each mission) by November 30, 2019. The plan will provide a reasonable alternative if a participant's personal physician provides a statement that the wellness coaching program, Rally missions or Quit for Life program is not medically appropriate for that individual. The personal physician should fill out, sign and send the Provider Alternative Action Form, carefully following all directions on the form. Forms for employees can be downloaded from the Delta Health Rewards page on Deltanet. Forms for covered Spouses can be downloaded from myuhc.com</p> <p>**You may earn up to \$1,100 in Delta Health Rewards (additional \$400 over the maximum standard reward amount of \$700) in 2019 if you are enrolled in the HRA or the Gold or Silver HSA and cover one or more dependent children. You will also receive an additional \$250 in automatic child funding for a total of up to \$1,350 to be deposited into your HRA or HSA (except the Bronze HSA). If you also cover a Spouse and have family coverage (except for the Bronze HSA), you can receive up to \$2,050 in Delta Health Rewards.</p> <p>If you are enrolled in the Bronze HSA, you do not earn additional Delta Health Rewards if you cover dependent children, and you do not earn automatic child funding. Under the Bronze HSA, you and your covered Spouse may each earn up to \$700.</p>			

HEALTHCARE BENEFITS HANDBOOK

You can use any of the following options to help you get to your total maximum Delta Health Rewards dollars. But remember, even if you complete every possible applicable activity, you will only receive your applicable maximum Delta Health Rewards dollars.

The chart below shows the additional health actions that you can choose from (including four new condition-based programs to earn Delta Health Rewards dollars:

2019 Additional Health Screenings (Including Condition-Based Programs)	Delta Health Rewards Dollars Earned in 2019	
	By You	
	If Not Covering Children or Covering Children in the Bronze HSA	If Covering Children (HRA, Gold HSA or Silver HSA)*
Receive a Cervical Screening (females)	\$50	\$50
Receive a Mammogram (females)	\$50	\$50
Receive a Colonoscopy	\$50	\$50
Participate in UHC's Maternity Support Program (females) (see earlier in this "Medical Plan Programs" section for details)	\$400	\$500
Participate in UHC's Spine and Joint Solution (SJS) Program (see earlier in this "Medical Plan Programs" section for details)	\$400	\$500
Participate in the Hello Heart Program for Coronary Artery Disease or Livongo for Diabetes Program (see later in this "Medical Plan Programs" section for details)	\$400	\$500
Participate in UHC's Cancer Support Program (see earlier in this "Medical Plan Programs" section for details)	\$525	\$750

* Child funding does not apply in the Bronze HSA.

Let's look at an example, assuming you are enrolled in the Gold HSA and do not cover any dependent children. If, based on your biometric screening, you do not meet the criteria outlined in the "2019 Health Actions" chart for Body Mass Index (BMI), total cholesterol, Fasting Blood Sugar (FBS) or A1c, and Blood Pressure to receive Delta Health Rewards dollars (\$400 total), you could still earn \$400 in Delta Health Rewards by participating in the alternative health actions described earlier in this section.

For more information on the condition-based programs and to see if you qualify, call Delta Health Direct at **877-912-1820**.

Complete a wellness program or Rally Missions to maximize your rewards.

Even if one or more of your biometrics are not within the healthy ranges, you and your Spouse will have the opportunity to earn the entire \$400 in Delta Health Rewards dollars related to those biometrics by completing a Delta Health Direct telephonic wellness program or three online Rally Missions.

Important note:

- Most Delta Health Direct telephonic wellness programs take up to ten weeks to complete, and each Rally Mission may take up to four weeks each to complete but can be completed concurrently.
- If you wish to receive the health reward dollars by completing the Delta Health Direct Quit for Life program, be aware that the program, depending on the individual, can take up to six months to complete. Enroll as soon as possible.
- The plan will provide a reasonable alternative if a participant's personal physician provides a statement that the wellness coaching program, Rally Missions or Quit for Life program is not medically appropriate for that individual. The personal physician should fill out, sign and send the Provider Alternative Action Form, carefully following all directions on the form. Forms for employees can be downloaded from the Delta Health Rewards page on Deltanet. Forms for covered Spouses can be downloaded from **myuhc.com**.

How to Get a Biometric Screening

There are three ways to get your Biometric Screening:

- First, Delta will sponsor a series of onsite screenings at locations throughout the system. Look for information at your worksite and on the Delta Health Rewards site located on Deltanet
- Second, you can get the biometric screening with your doctor. To do so, however, you need to prepare in advance, BEFORE you go to your doctor. You should download and print your pre-populated Physician Results Form. You can access that link from the Delta Health Rewards page on Deltanet or from the Rewards page on Rally and take it with you to your doctor. Ask your doctor to complete the form, sign and submit it to UnitedHealthcare on your behalf, or you can submit it yourself after having your doctor complete it. Using the pre-populated form helps your Delta Health Rewards process faster
- Third, you can get your biometric screening at a Quest location near you. Before you go, download and print your pre-populated Quest Form as described above.

Notice Regarding Wellness Program

The Delta Health Rewards Program (the “program”) is a voluntary wellness program open to participants in the Delta Account Based Healthcare Plan. It is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the program you will be asked to complete a voluntary online Rally Health Survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., lung problems or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for testing of your total cholesterol and Fasting Blood Sugar (FBS). You are not required to complete the online Rally Health Survey or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the online Rally Health Survey or participate in the biometric screening will receive an incentive in the form of Delta Health Rewards employer contributions to an HSA or HRA as outlined in the chart on the previous page. Although you are not required to complete the online Rally Health Survey or participate in the biometric screening, only plan participants who do so will receive the employer contribution for these health actions under the program.

If you are unable to participate in any of the health-related activities (biometric screenings or Quit for Life program), you may be entitled to a reasonable alternative if your personal physician provides a statement that the wellness coaching, Rally Missions or Quit for Life program is not medically appropriate for that individual. The personal physician should fill out, sign and send the Provider Alternative Action Form, carefully following all directions on the form. Forms for employees can be downloaded from the Delta Health Rewards page on Deltanet. Forms for covered Spouses can be downloaded from **myuhc.com**.

The information from your online Rally Health Survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Delta Account-Based Health Care Plan, such as disease management and health improvement programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

The health plan is required by law to maintain the privacy and security of your personally identifiable health information. The Delta Health Rewards Program (the “program”) will not disclose your individual health information to Delta. However, the program and Delta may use aggregate information collected to design a program based on identified health risks in the workplace. The program will never disclose any of your personal health information except as necessary to respond to a request from you for a reasonable alternative or unless expressly permitted by law. Medical information that personally identifies you that is provided in connection with the program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are UnitedHealthcare nurses, specialists and wellness coaches in order to provide you with services under the program.

In addition, all medical information obtained through the program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the program, you will be notified immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, contact Delta Health Direct at 877 912 1820. Or, if your question is about protections against discrimination and retaliation, please contact the Ethics & Compliance HelpLine at 800-253-7879.

Delta Health Direct Can Help

If your biometric numbers are outside of the healthy range, or if you want to quit tobacco, Delta Health Direct offers helpful resources; call **877-912-1820** to get started. You may receive a phone call from a member of the Delta Health Direct team to discuss your responses to the online Rally Health Survey questions. Calls are confidential and made by UnitedHealthcare nurses, coaches and specialists dedicated to Delta members.

Employee Assistance Program (EAP)

The EAP is a confidential information and consultation service provided as a free benefit to you by Delta through OptumHealth Behavioral Solutions. Please review the Employee Assistance Program (EAP) website, which can be found on Deltanet, for more information about eligibility and features of the Program.

You may also call the EAP at **800-533-6939** or visit **myuhc.com**.

Cleveland Clinic MyConsult® Online Medical Second Opinion

If you have been diagnosed with a condition that affects your quality of life or one that may be more serious, it's always a good idea to get a second opinion. But how much more peace-of-mind would you have if you could get your second opinion from a leading specialist from one of the world's best hospitals? Well, now you can find out.

Cleveland Clinic's My**Consult** Online Medical Second Opinion is offered as a covered benefit to those Delta members and covered dependents enrolled in Delta medical coverage.*

My**Consult** provides secure, online access to Cleveland Clinic's physician specialists who will examine your records and diagnostic information and provide you with a comprehensive online report that you can discuss with your family and personal physician, all by the click of a mouse. My**Consult** covers over 1,200 diagnoses and these diagnoses can include conditions that impact your quality of life or conditions that may be more serious.

All employees and dependents enrolled in Delta's medical plan have access to Health Advocate, a service that can assist you in the collection of your medical records during the My**Consult** process. This service is voluntary and covered at no cost to eligible members. Call Delta Health Direct at **877-912-1820** for assistance.

* This service is not available to patients with mailing addresses in North Dakota or Guam.

Cleveland Clinic features board-certified physicians who are experts in their field. Most lecture and publish extensively. Many also hold leadership positions in their professional organizations and lead research trials to bring the latest medical advancements to patients as quickly as possible.

For more information about how you can request a second opinion through the Cleveland Clinic's MyConsult Online Medical Second Opinion service, please visit [eclevelandclinic.org/Delta](https://www.clevelandclinic.org/Delta) or call **800-223-2273, ext. 43223**.

Fusion Health SleepCharge™ Program

Lack of sleep keeps you from feeling your best and staying alert at work, at home or during other activities. The Plan partners with FusionHealth to help you evaluate your sleep habits and learn about health conditions related to poor sleep.

This program is designed for sleep-disordered breathing, sleep apnea and/or severe snoring or periods of no breathing while sleeping. Through the SleepCharge™ Program, you will have access to a medically-validated online sleep health evaluation and sleep testing and treatment is available for eligible participants at risk for sleep apnea.

The program provides:

- At-Home Sleep Test – identify medically disordered sleep from the comfort of your home
- Sleep Apnea Treatment – personalized treatment for sleep apnea, including medical devices to assist with breathing while sleeping. Additional charges for treatment and medical devices may apply
- Dedicated care managers and sleep experts

For additional program information or to speak with a member of the FusionHealth Participant Resource Center, call **1-877-615-7257** or visit the SleepCharge website at www.sleepcharge.com/delta/.

Hello Heart

The Hello Heart program is designed for people with prehypertension and hypertension who have an average blood pressure above 120/80. If you have been diagnosed with high blood pressure or heart disease and are controlling your condition with medication, you are also eligible for the program. Hello Heart empowers you to track and understand your blood pressure using your smart phone. Hello Heart program participants receive a free wireless blood pressure monitor and personalized heart healthy tips.

With Hello Heart, program participants can do the following tasks:

- Track blood pressure, weight and BMI
- Set medication reminders
- Import lab results and get clear explanations of their numbers
- Catch potential issues early
- Access easy-to-apply heart healthy tips through personalized digital coaching

Hello Heart is offered on iPad, iPhone and Android devices. For more information about the program, email support@helloheart.com.

Livongo for Diabetes Program

The Livongo for diabetes program makes managing your diabetes as easy as possible at no additional cost to you. The program includes valuable tools to check and track blood sugar, instant personalized tips, real-time support when blood sugar is out of range and automatic data uploads with the ability to send data directly to your doctor. UHC plan members (employees and their covered spouses and dependent children) who have been diagnosed with type 1 or type 2 diabetes are eligible to participate.

Eligible plan members can join the Livongo for Diabetes Program by visiting hi.livongo.com/DELTA or by calling **1-800-945-4355** and mentioning the registration code "**DELTA**". When you join, a complimentary welcome kit will be sent to you containing the following items:

- 1 Livongo blood glucose meter
- 150 Livongo test strips
- 100 Livongo lancets
- 1 lancing device
- 2 bottles of control solution
- 1 USB charger for the blood glucose meter
- 1 carrying case
- Instructions

Livongo supplies are mailed to members at no cost. Supply refills (strips, lancets, etc.) are also free.

Diabetes medications such as insulin and pills are not covered under this program, but are eligible expenses under the health plan. See the Prescription Drug list (PDL) for a list of covered medications. You can view UHC's PDL on Benefits Direct. You can also access the drug list at myuhc.com.

ParentSteps

Many couples face the challenges and wide variations in practice patterns of fertility treatment. ParentSteps is an INFERTILITY DISCOUNT PROGRAM offering support to individuals seeking infertility treatment. See "Covered Expenses" in the "Medical Benefits" section of this handbook to determine what infertility treatment may be considered as Covered Services by the plan. If the services you need are not covered by the Plan, the ParentSteps Program may provide you discounts on infertility services that you must pay for out of pocket. This Program does not provide additional insurance coverage for fertility treatment.

This program provides access to:

- Infertility Centers of Excellence: ParentSteps provider network is comprised of centers that have gone through a rigorous qualification process. These clinics have high pregnancy rates AND low incidence of multiple births
- Specialized clinical consultants: Trained nurses specializing in infertility are available to provide guidance and education on causes of infertility, treatment alternatives, appropriateness and efficacy of treatment types and risks of multiples
- Medical treatment discount: ParentSteps has negotiated discounts with infertility Centers of Excellence and is able to provide savings off retail price for fertility treatment
- Pharmacy discount: ParentSteps has partnered with drug manufacturers and distributors to provide savings on fertility medications and offers the ability to purchase treatment cycles and infertility medications at group discount prices

For information concerning infertility treatment and the ParentSteps program, please call Delta Health Direct at **877-912-1820** or visit **myoptumhealthparentsteps.com**.

Sleepio

Sleepio is a digital sleep improvement program, scientifically proven to work. You'll start by taking a 2-minute sleep quiz to discover your Sleep Score and receive a simple, personalized tip that you can put into practice at night. They'll also provide you with more detailed, tailored advice related to the specific problems you're having with your sleep.

If you want more help, you can continue to Sleepio's online Cognitive Behavioral Therapy (CBT) program. Over several weeks, you'll learn evidence-based techniques to improve your sleep. CBT trains people to address the mental (or cognitive) factors associated with insomnia, such as the 'racing mind', trouble falling or staying asleep, lack of a general sleep routine, and to overcome the worry and other negative emotions that accompany the experience of being unable to sleep.

The program consists of online weekly sessions of 10-15 minutes each, which you can view wherever and whenever is convenient for you, on your computer, tablet or phone. You'll also gain access to a library of articles and guides which cover common problem areas, like pregnancy and sleep, shift work, and jet lag.

Sleepio's virtual sleep expert, The Prof, will guide you through the program. The Prof will help you get your sleep back on track by providing techniques that are tailored to your specific problems and progress. You can enroll via Rally or directly using the URL **www.sleepio.com/delta**.

Virtual Visits

Virtual Visits is a service that includes the diagnosis and treatment of low acuity medical conditions for covered persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **myuhc.com** or by calling the telephone number on your ID card.

Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by an in-person physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities.

Travel Health Vaccinations

Delta provides designated flight attendants and pilots with company-paid yellow fever vaccinations and the prescription medication Malarone for malaria prevention. Non-crew employees traveling on international business may obtain similar company-paid travel vaccinations. Company Business travelers may contact Air Crew & Passenger Health Services (ACPHS) for itinerary-specific travel health recommendations.

Employees enrolled in a DABHP Medical Option who travel for personal reasons may take advantage of 100% fully covered travel health vaccinations when administered by a UHC Network Provider. Malarone is subject to the DABHP pharmacy coinsurance.

Certain vaccinations also may be covered under the Preventive Care benefit (see "Preventive Care" in the "Delta Account-Based Healthcare Plan" section or "Preventive Care – Routine Physicals, Women's Preventive Service, Annual Colonoscopies, and Well Child Visits" in the "What The Delta Medical Plans Cover" section).

To find a UHC provider who administers vaccinations, visit **myuhc.com** and select "Find A Doctor". You can find more information about Travel Health Vaccinations on the Health & Insurance site of Employee Connection.

International Medical Assistance

International SOS (SOS) provides you with global medical assistance while you are traveling internationally on company business outside your home country of record. Free of charge to you, the program provides medical advice, referrals, case management and evacuation, if necessary. Medical treatment expenses incurred are billed against your health plan as network urgent care.

Contact SOS before you seek medical attention (if possible) by calling collect **215-245-4707**. For more information, go to **www.internationalsos.com** and enter Delta's Corporate Medical Membership number: 11BCMA000044.

Travel tip: If you travel internationally on company business, print an SOS wallet card on Deltanet and carry it with you at all times.

DELTA ACCOUNT-BASED HEALTHCARE PLAN

The Delta Account-Based Healthcare Plan (DABHP) empowers you to make healthcare benefit choices that best fit your needs. Both Delta and UnitedHealthcare (UHC) provide tools in connection with your medical plan which help you manage your healthcare and make good decisions.

Your DABHP Medical Options

You may choose to enroll in a DABHP Medical Option that is accompanied by a Health Reimbursement Account (HRA) or a Health Savings Account (HSA).

Medical options include the following network-based choices, administered by UHC:

- HRA Medical Option
- Out-of-Area (OOA) HRA Medical Option, if eligible
- Gold HSA Medical Option
- Silver HSA Medical Option
- Bronze HSA Medical Option
- Gold Out-of-Area (OOA) HSA Medical Option, if eligible
- Retiree & Survivor Bronze HSA Medical Option – this is the only option available to you under the DABHP is you are a retiree or a survivor of a retiree
- Retiree & Survivor Bronze OOA HSA Medical Option (see callout box below) – this is the only option available to you under the DABHP is you are a retiree or a survivor of a retiree
- Puerto Rico Out-of-Area (OOA) Medical Option, if eligible

If you live within the UHC network area and you are an active or inactive employee, you are only offered the network options (HRA, Gold HSA, Silver HSA, Bronze HSA) during your enrollment period. Retirees and survivors of retirees under age 65 who live within the UHC network area are offered only the Retiree & Survivor Bronze HSA during enrollment.

If you live outside the UHC network (except for Puerto Rico residents), you will not only be offered the OOA HRA Medical Option and OOA Gold HSA Medical Option (for active and inactive employees) or the Retiree & Survivor Bronze OOA HSA Medical Option (for under age-65 retirees and survivors of retirees) during your enrollment period, but you also have the choice to enroll in a network option. You should choose the option that best suits your needs. Keep in mind that if you choose one of the network options and see a Non-Network Provider, your benefits will be less and your expenses will be higher than if you use a Network Provider. You can verify that you have adequate access to Network Providers by visiting myuhc.com and selecting "Find A Doctor".

If you are eligible for the Puerto Rico OOA Medical Option, you will not be offered the network options listed above during your enrollment period; you will only be eligible for the Puerto Rico OOA Medical Option.

Key Features of the DABHP Medical Options

The DABHP HRA and HSA options are “account-based.” This means that, in addition to providing comprehensive medical coverage, these options also feature an account that may be used to help pay for eligible medical expenses. With account-based healthcare plans, also known as “consumer-driven” or “consumer-directed” health plans, you have more visibility to healthcare costs and are empowered to make more choices about your health benefits – and pay according to how you use them.

There are no Copayments with any of the medical options offered under the DABHP, care is not required to be coordinated through a Primary Care Physician – and referrals to UHC network specialists are not required.

All of the medical options under the DABHP have three key features:

- Preventive Care benefits
- A comprehensive medical plan that begins paying after you meet an annual Deductible
- Tools and programs to help you manage your health – and your costs

The HRA and OOA HRA Medical Options have the added key feature of being accompanied by a Health Reimbursement Account to pay for eligible medical expenses. However, if you have a balance in your Health Reimbursement Account at the end of the prior year and change your plan option from an HRA Medical Option to an HSA Medical Option the following calendar year, any available HRA balance will become a Post-Deductible HRA that can be used alongside the HSA to pay for eligible medical expenses. See the “Post-Deductible HRA” callout box in “How the HRA Medical Options Work” for more information.

The Gold HSA, Silver HSA, Bronze HSA, OOA Gold HSA, and Retiree & Survivor Bronze HSA Medical Options have the added key feature of being high deductible health plans that are required in order for a participant to be eligible to contribute to a Health Savings Account to help pay for eligible medical expenses.

Preventive Care

Preventing disease, and detecting disease early if it occurs, is important to living a healthy life. And the better your health, the lower your healthcare costs are likely to be. Preventive Care is designed to encourage you to actively monitor your health. Annual check-ups can often catch potential problems early – and, in some cases, prevent serious illness from developing. Examples of Preventive Care services may include:

- Annual physicals
- Annual Well Woman visits and related services
- Childhood and certain adult immunizations
- Mammograms
- Colonoscopies

Participants in the DABHP options are eligible to receive certain Preventive Care services, based on age, gender and other factors, with no cost-sharing (Coinsurance and Deductibles). Additional Preventive Care services for women are also covered.

Under the network options (HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA), you must see a Network Provider to receive Preventive Care coverage at 100%. If you are enrolled in these network options, Preventive Care services performed by or purchased from a Non-

Network Provider are not covered. Please note that if you are seeking Preventive Care and are unable to find a network provider, visit myuhc.com or contact Delta Health Direct at **877-912-1820** for assistance. If through this process of working with UnitedHealthcare, you collaboratively cannot locate a network provider to perform a Preventive Care service, the plan is required to cover that visit at 100%. *Understand that in this situation, however, you need to contact UHC **before** going to the doctor for your Preventive Care visit to confirm if it will be covered by the plan; there is no guarantee of payment otherwise.*

When enrolled in an out-of-area option (OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or Puerto Rico OOA), you may see either a Network Provider or Non-Network Provider for Preventive Care services and receive coverage. Just remember that your out-of-pocket costs are generally less when seeing a Network Provider.

The Delta plans cover Preventive Care services in accordance with U.S. Preventive Services Task Force (USPSTF) Grade A and B guidelines, the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for preventive services for women, infants, children and adolescents, and the Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC).

To see which Preventive Care services are recommended for various age groups, review the guidelines on the USPSTF website at www.uspreventiveservicestaskforce.org.

Following the Task Force and other guidelines noted above, along with the advice of your doctor, can help you stay healthy. Talk to your doctor about your specific health questions and concerns, and follow his or her recommendations.

A note about preventive services and provider billing: Your provider assigns a code for your service after each doctor's visit. Occasionally, providers code a Preventive Care visit as diagnostic if they detect something they want to follow up on. If this happens, UHC may assume this visit was not for Preventive Care, and the visit may not be paid as a Preventive Care visit. If you encounter a network Preventive Care claim or Preventive Care out-of-area claim not being processed at 100% coverage, without meeting the Deductible, and you believe it to have been a true Preventive Care claim incurred through a Network Provider or under the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or Puerto Rico OOA Medical Option, contact Delta Health Direct at **877-912-1820** and ask to have the claim reprocessed. If the claim in question falls within the Preventive Care Service guidelines described above, UHC will reprocess the claim at the appropriate benefit level.

One-Year Claims Filing Deadline for Non-Network Claims

The DABHP Medical Options have a one-year claims filing limit if you use a provider that does not participate in UHC's Choice Plus Network, with the exception of the Puerto Rico OOA Medical Option, which has a two-year claims filing limit. All claims for non-network medical services must be submitted to UHC within one year of the date of service, or within two years of the date of service for medical services under the Puerto Rico OOA Medical Option. See the "Claims Information and Appeals" section of this handbook for details.

How the DABHP Options Work With an FSA and a Post-Deductible HRA

If you enroll in an HRA Medical Option and contribute to Delta's Healthcare FSA, your FSA is a Full Purpose FSA. Generally, you can use these FSA funds to reimburse yourself for eligible out-of-pocket medical, dental, prescription drug and vision care expenses, as well as certain over-the-counter items. However, if you enroll in an HRA Medical Option, when you incur an Eligible Expense, that expense is submitted first through your HRA. If all or a portion of that Eligible Expense is not paid by the HRA or through the medical option, then it may be submitted to the FSA.

If you enroll in an HSA Medical Option and contribute to Delta's Healthcare FSA, your FSA is a Limited Purpose FSA. You can use these FSA funds to reimburse yourself for non-medical healthcare expenses, such as dental and vision care expenses. You also can use the Limited Purpose FSA for reimbursement of qualified medical expenses you pay between meeting your HSA Deductible and reaching the Annual Coinsurance Maximum (after which the plan pays 100% of eligible expenses).

Note: If you were previously enrolled in an HRA Medical Option and have a Post-Deductible HRA, eligible expenses that exceed your Deductible will be paid through your Post-Deductible HRA until there is no longer a balance in that HRA or you reach your Annual Coinsurance Maximum. After your Post-Deductible HRA balance is zero, eligible expenses for the year that are in excess of your Deductible but below your Annual Coinsurance Maximum may be reimbursed to you from your Limited Purpose FSA. See the "If You Are Enrolled in a Delta HRA Medical Option and Change to a Delta HSA Medical Option" in "How the HRA Medical Options Work" for more information.

Full details about how the HRAs and the HSA work together with the FSA appear in the "Flexible Spending Accounts" section of this handbook.

How the HRA Medical Options Work

Delta's HRA Medical Options manage healthcare claims differently from traditional healthcare plans. Read on to learn how the following features work under the HRA Medical Options:

- Delta-provided Health Reimbursement Account
- Annual Deductible
- Coinsurance
- Annual Coinsurance Maximum
- Behavioral health and substance use benefits
- Prescription drug benefits

Health Reimbursement Account

The HRA Medical Options combine the flexibility of a medical benefit plan with a recordkeeping account called a Health Reimbursement Account (HRA) (see "Terms to Know" at the end of this handbook for a definition).

Delta Health Rewards and Your HRA

If you enroll in the HRA Medical Option for 2019, the amount of HRA dollars you receive for the year is based on the coverage tier you elect and the amount that you and your Spouse earn under the Delta Health Rewards program during the year. For a list of the health actions and dollars that can be earned, see "Delta Health Rewards Program" under "Medical Plan Programs" earlier in this "Medical Benefits" section.

2019 HRA Amounts		
	HRA Medical Option	OOA HRA Medical Option
Employee Only	Up to \$700 can be earned through Delta Health Rewards	Up to \$700 can be earned through Delta Health Rewards
Employee & Spouse	Up to \$1,400 can be earned through Delta Health Rewards	Up to \$1,400 can be earned through Delta Health Rewards
Employee & Child(ren)	\$250 automatic deposit for children (plus up to an additional \$1,100 can be earned through Delta Health Rewards)	\$250 automatic deposit for children (plus up to an additional \$1,100 can be earned through Delta Health Rewards)
Family	\$250 automatic deposit for children (plus up to an additional \$1,800 can be earned through Delta Health Rewards)	\$250 automatic deposit for children (plus up to an additional \$1,800 can be earned through Delta Health Rewards)

If you enroll in an HRA Medical Option for 2019, any Delta Health Rewards dollars that are earned are included in your HRA amounts for 2019. In addition, any HRA rollover balance you may have at the end of 2018 will continue to be available for use toward your 2019 medical expenses, including through a Post-Deductible HRA if you choose to enroll in one of the HSA Medical Options for 2019. See "Post-Deductible HRA" later in this section for more information about Post-Deductible HRAs.

Using HRA Dollars

In the HRA Medical Options, when you have a covered medical expense, the full cost of the expense (discounted by Network Providers) is automatically deducted from your HRA. No HRA dollars are used for prescription drug expenses or copays in the HRA Medical Options.

Once the Deductible has been reached, the HRA Medical Options operate like traditional Coinsurance plans: You pay a percentage, and the plan pays the rest. If you reach the Annual Coinsurance Maximum, any additional covered expenses are paid in full by the plan for the remainder of the calendar year.

Once you have exhausted the dollars in your HRA, you are responsible for your share of any remaining Deductible or Coinsurance amount.

Carrying Over Unused HRA Dollars

As long as you remain eligible for and are enrolled in a Delta HRA Medical Option, HRA dollars remaining at the end of the plan (calendar) year, carry over for use in the next year. The amount of carry-over is added to your next plan year's HRA amount, so you have more HRA dollars to use, decreasing the portion of your annual Deductible that you need to pay out of pocket.

Your HRA dollars remain with you regardless of the option you choose:

- If you move from the HRA option to an HSA option, any HRA account balance you have will become a Post-Deductible HRA (see the "Post Deductible HRA" callout box on the following page)
- If you move from an HSA option to the HRA option, two things happen:
 - You become responsible for the monthly HSA service fee charged by Optum Bank; if you go back to an HSA option in the future, the fee will no longer apply, and
 - Any post-deductible HRA balance will move with you to your HRA account where it will be used to pay eligible medical expenses

Note: *If you elect not to participate in a Delta HRA or HSA Medical Option at any time, any account balance in the HRA or Post-Deductible HRA is reduced to zero and will not be reinstated, even if you come back into a Delta HRA or HSA Medical Option at a later time.*

The HRA Is Not Portable

Because Delta provides the HRA dollars and you do not make contributions to your HRA, you do not take your HRA balance (or Post-Deductible HRA balance) with you if you leave Delta. However, if you elect an HRA Medical Option as COBRA continuation coverage, your HRA balance (or as a Post-Deductible HRA if you choose an HSA Medical Option instead; see callout on the following page) remains available as part of that coverage.

Post-Deductible HRA

If you are enrolled in an HRA Medical Option and choose to enroll in one of the HSA Medical Options during a future enrollment period, you won't lose the balance you currently have in your HRA. Instead, this balance will be converted to a Post-Deductible HRA that can be used in connection with the HSA Medical Option.

When you retire, the Retiree & Survivor Bronze HSA or Retiree & Survivor Bronze COA HSA Medical Option are the only DABHP medical options available to you. If you enroll in one of these options, you will not lose unused HRA dollars due to this change to an HSA Medical Option. Instead, your balance will automatically be converted to a Post-Deductible HRA that can be used in connection with the HSA option.

Here is how the Post-Deductible HRA works in connection with a Delta HSA Medical Option:

- First, you must meet the deductible as determined by your HSA Medical Option, or if less, the high-deductible health plan deductible amount specified by the Internal Revenue Code (for 2019, this amount is \$1,350 for employee-only coverage or \$2,700 for all other coverage categories, for example, employee + children or family coverage). Note: If you are enrolled in any other coverage category other than employee only, the entire IRS required minimum family deductible of \$2,700 must be met in full before your Post-Deductible HRA will start paying any benefits. It does not start paying for an individual once they meet the individual deductible regardless of which HSA plan they are in.
- After you have met this deductible, but before you reach your Annual Coinsurance Maximum, when you have a covered expense (including a prescription drug expense), the full cost of the expense (discounted by Network Providers) is automatically deducted from your Post-Deductible HRA balance
- Covered expenses are paid by your Post-Deductible HRA until either your HSA Medical Option Annual Coinsurance Maximum (when the plan begins to pay 100% for the remainder of the year) is met or the Post-Deductible HRA balance is depleted
- Once your Post-Deductible HRA is depleted and before your Annual Coinsurance Maximum is reached, you can choose to use your Health Savings Account or Limited Purpose Flexible Spending Account for reimbursement of your 20% Coinsurance amount. See "How the HSA Medical Options Work" for information on using your HSA dollars

Please Note: If you elect not to participate in a Delta HRA or HSA Medical Option at any time, any account balance in the Post-Deductible HRA is reduced to zero and will not be reinstated, even if you come back into a Delta HRA or HSA Medical Option at a later time.

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Annual Deductible

The annual Deductible is the dollar amount of covered expenses that you must pay before the plan begins to pay benefits each calendar year. With the HRA Medical Options, this amount is higher than with traditional preferred provider organization (PPO) or point-of service (POS) plans; however, your HRA dollars are automatically used first for medical expenses to help satisfy your annual Deductible. No HRA dollars are used for prescription drug expenses or copays in the HRA Medical Options. Any Deductible amount that remains after all the HRA dollars in your account have been applied are your responsibility.

The HRA Medical Option has separate Deductible amounts for network services and non-network services; the non-network Deductible is higher. If you are enrolled in the OOA HRA Medical Option, you have one Deductible to meet, regardless of whether you receive services through the UHC network.

Under both of the HRA Medical Options, your Copays/Coinsurance for Prescription Drugs do not count toward your Deductible and there is a separate Pharmacy Out of Pocket Maximum that applies.

Any amounts in excess of the Eligible Expense are not covered by the Plan and therefore are not applied to the Deductible. You, not the Plan, must always pay 100% of these excess amounts.

2019 HRA Medical Option Annual Deductibles			
	HRA Medical Option		OOA HRA Medical Option
	Network	Non-Network	
Employee Only	\$1,350 (HRA pays medical claims first)	\$2,700 (HRA pays medical claims first)	\$1,350 (HRA pays medical claims first)
Employee & Spouse <i>(Individual/Family)</i>	\$1,350/\$2,700 (HRA pays medical claims first)	\$2,700/\$5,400 (HRA pays medical claims first)	\$1,350/\$2,700 (HRA pays medical claims first)
Employee & Child(ren) <i>(Individual/Family)</i>	\$1,350/\$2,700 (HRA pays medical claims first)	\$2,700/\$5,400 (HRA pays medical claims first)	\$1,350/\$2,700 (HRA pays medical claims first)
Family <i>(Individual/Family)</i>	\$1,350/\$4,000 (HRA pays medical claims first)	\$2,700/\$8,000 (HRA pays medical claims first)	\$1,350/\$4,000 (HRA pays medical claims first)

How Family Members Meet the Deductible

Unless you are enrolled in employee only coverage, no one family member is required to meet the overall plan Deductible.

For employee & spouse, employee & child(ren) and family levels of coverage, a family member is only required to meet his or her individual Deductible of \$1,350 network/\$2,700 non-network for the HRA Medical Option before plan benefits and Coinsurance apply.

Once an enrolled family member meets his or her individual Deductible, the plan begins to pay his or her eligible expenses at the applicable Coinsurance amount (see chart in the "Coinsurance" section). Then, Deductible-eligible medical expenses paid by any combination of the other family members will accumulate to meet the combined family Deductible. If the family Deductible is met before an individual family member reaches his or her own individual Deductible, plan benefits and Coinsurance apply for all family members.

Paying the Deductible

Your HRA account is used to help meet your annual Deductible for medical expenses. If you have used all your HRA dollars but still have not met the Deductible, you pay the full cost of further Covered Services (which are discounted by Network Providers) that year up to the point that you have met your annual Deductible.

Coinsurance

Once you and/or your dependents have met your annual Deductible, you share medical expenses with the plan. Your portion of these expenses is called your Coinsurance.

The HRA Medical Option generally pays 80% of the cost of Network Charges while you pay the remaining 20%. For Non-Network Charges, the HRA Medical Option generally pays 60% of the Eligible Expense after the non-network Deductible is met.

The OOA HRA Medical Option generally pays 80% of the Eligible Expense for Covered Services, while you pay the remaining 20%.

2019 HRA Medical Option Coinsurance			
	HRA Medical Option		OOA HRA Medical Option
	Network	Non-Network	
You Pay	20%	40%*	20%**
Plan Pays	80%	60%*	80%**

* Based on Eligible Expenses (see "Eligible Expenses for Non-Network Benefits" earlier in this "Medical Benefits" section for details on how Eligible Expense is determined). In addition to the Coinsurance, you also are responsible for 100% of the difference between billed charges and the Eligible Expense. The plans do not cover this difference, and these amounts do not apply to the Deductible or Annual Coinsurance Maximum.

**Based on Eligible Expenses (see "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how Eligible Expense is determined). In addition to the Coinsurance, you are responsible for 100% of the difference between billed charges and the Eligible Expense. The plans do not cover this difference, and these amounts do not apply to the Deductible or Out-of-Pocket Maximum.

Annual Coinsurance Maximum

After you have met the Deductible, you will begin to pay your applicable Coinsurance on your Eligible Expenses. However, there is an Annual Coinsurance Maximum applied for the calendar year. Once your Coinsurance payments reach this dollar limit, the plan pays 100% for Covered Services for the remainder of the plan (calendar) year.

There are separate Annual Coinsurance Maximums for network and non-network services received under the HRA Medical Option. The OOA HRA Medical Option has its own Annual Coinsurance Maximum amounts.

Any amounts in excess of the Eligible Expense are not covered by the Plan and therefore are not applied to the Annual Coinsurance Maximum. You, not the Plan, must always pay 100% of these excess amounts.

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2019 HRA Medical Option Annual Coinsurance Maximums (Amount is in Addition to the Deductible)			
	HRA Medical Option		OOA HRA Medical Option
	Network	Non-Network	
Employee Only	\$2,500	\$5,000	\$2,500
Employee & Spouse <i>(Individual/Family)</i>	\$2,500/\$3,750	\$5,000/\$7,500	\$2,500/\$3,750
Employee & Child(ren) <i>(Individual/Family)</i>	\$2,500/\$3,750	\$5,000/\$7,500	\$2,500/\$3,750
Family <i>(Individual/Family)</i>	\$2,500/\$5,000	\$5,000/\$10,000	\$2,500/\$5,000

How Family Members Meet the Annual Coinsurance Maximum

For employee & spouse, employee & child(ren) and family levels of coverage, a family member is required to meet his or her individual Annual Coinsurance Maximum before the plan begins paying 100% for that one family member.

Once the network Annual Coinsurance Maximum is met, additional covered network services are covered at 100% for the remainder of the year. Likewise, once the non-network Annual Coinsurance Maximum is met, additional covered non-network expenses are paid at 100% of the Eligible Expense for the remainder of the year. Any amounts charged in excess of the Eligible Expense are not covered under the plan and must be paid 100% by the covered individual, even if the non-network Annual Coinsurance Maximum has been met.

Example: An individual who has family coverage under the HRA Medical Option would reach the network Annual Coinsurance Maximum once his or her covered network medical expenses add up to \$2,500 (after the Deductible is paid) for the year. This individual's covered network medical expenses would then be paid by the plan at 100% for the rest of the year. The individual would not have to wait until the entire family's covered network expenses reach \$5,000 (after the Deductibles is paid) for this to happen.

Place of Service Surcharge

The HRA Medical Option includes a \$250 "place of service surcharge" that applies to outpatient Major Diagnostics – CT scans, PET scans, MRIs, MRAs, nuclear medicine and major diagnostic services – if these procedures are not done at a free-standing facility. This \$250 place of service surcharge also applies to outpatient surgeries that are performed in a hospital. This surcharge may be avoided by making sure that the facility where these outpatient services are received is independently run, not managed, billed or otherwise associated with a hospital. This surcharge does not apply to labs and X-rays unless they are done in conjunction with an outpatient surgery at a hospital.

This \$250 place of service surcharge applies to Network and Non-Network Services and must be paid in addition to the annual Deductible and Coinsurance amount. However, place of service surcharges that you pay count towards the Annual Out-of-Pocket Maximum and will not apply once the Annual Out-of-Pocket Maximum is reached.

For assistance in locating a free-standing facility, please contact Delta Health Direct at **877-912-1820**.

Behavioral Health and Substance Use Benefits

Your mental health is just as important as your physical health. Therefore, when you enroll in one of the HRA Medical Options, you automatically receive behavioral health benefits and substance use treatment benefits (BH/SU) through OptumHealth Behavioral Solutions. You may seek behavioral health services either through a Network or Non-Network Provider.

Costs for behavioral health services apply toward your HRA Medical Option's Deductibles and Annual Coinsurance Maximums.

Prior Authorization from OptumHealth Behavioral Solutions is required for certain BH/SU services. Be sure to read the "When You Must Notify UHC or OptumHealth Behavioral Solutions" section earlier in this "Medical Benefits" section for details.

For full coverage details about BH/SU services, refer to the section, "What the Delta Medical Plans Cover," which appears later in this "Medical Benefits" section of this handbook.

Prescription Drug Benefits

Prescription drug benefits for both retail and mail order prescriptions are included with the HRA Medical Options. UnitedHealthcare administers the program, with the mail order pharmacy administered by OptumRx™, a UnitedHealth Group Company.

In the HRA Medical Options, your prescription drug expenses do not count toward your annual medical Deductible and HRA dollars are not applied to pay your drug expenses.

In addition, there is an annual Pharmacy Out-of-Pocket Maximum that is separate from and in addition to the medical Annual Coinsurance Maximum. That amount is \$1,250 for individuals and \$2,500 for families. This Pharmacy Out-of-Pocket Maximum includes Tier 1 Copays and the Coinsurance you pay for drugs in Tier 2 and Tier 3. Drugs in Tier 4 are not covered and do not apply to the Pharmacy Out-of-Pocket Maximum. Once the Pharmacy Out-of-Pocket Maximum is met, your covered prescription costs (excluding for drugs in Tier 4) are paid by the plan at 100% for the remainder of the calendar year.

Full details about the prescription drug benefits appear later in this section.

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HRA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 HRA Medical Option		
	Network	Non-Network
Health Reimbursement Account (HRA) Dollars		
Employee Only	Up to \$700 can be earned through Delta Health Rewards ¹	
Employee & Spouse	Up to \$1,400 can be earned through Delta Health Rewards ¹	
Employee & Child(ren)	\$250 for children (plus up to \$1,100 can be earned through Delta Health Rewards) ¹	
Family	\$250 for children (plus up to \$1,800 can be earned through Delta Health Rewards) ¹	
1. You may earn these amounts to be deposited in your 2019 HRA based on actions completed under the Delta Health Rewards program from January 1, 2019 to November 30, 2019. To see what you have earned, go to Rally SM on myuhc.com or contact Delta Health Direct at 877-912-1820.		
Annual Deductible (HRA pays first) (medical expenses only)		
Employee Only	\$1,350	\$2,700
Employee & Spouse (Individual/Family)	\$1,350/\$2,700	\$2,700/\$5,400
Employee & Child(ren) (Individual/Family)	\$1,350/\$2,700	\$2,700/\$5,400
Family (Individual/Family)	\$1,350/\$4,000	\$2,700/\$8,000
Coinsurance (% paid by plan)	Plan pays 80% after Deductible	Plan pays 60% of the Eligible Expense ² after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use Benefits; Excludes Prescription Drug Benefits; Amount is in Addition to the Deductible)		
Employee Only	\$2,500	\$5,000
Employee & Spouse (Individual/Family)	\$2,500/\$3,750	\$5,000/\$7,500
Employee & Child(ren) (Individual/Family)	\$2,500/\$3,750	\$5,000/\$7,500
Family (Individual/Family)	\$2,500/\$5,000	\$5,000/\$10,000
Out-of-Pocket Maximum		
HRA maximums include Deductible, Annual Coinsurance Maximum and prescription drug Out-of-Pocket Maximum of \$1,250 for Employee Only coverage and \$2,500 for other coverage tiers		
Employee Only	\$5,100	\$8,950
Employee & Spouse (Individual/Family)	\$5,100/\$8,950	\$8,950/\$15,400
Employee & Child(ren) (Individual/Family)	\$5,100/\$8,950	\$8,950/\$15,400
Family (Individual/Family)	\$5,100/\$11,500	\$8,950/\$20,500
Lifetime Max. Medical Benefit	No limit	

HEALTHCARE BENEFITS HANDBOOK

2019 HRA Medical Option		
	Network	Non-Network
Behavioral Healthcare³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Chiropractic Care <i>20 visits per calendar year</i>	80% covered after Deductible	Not covered
Durable Medical Equipment³ <i>Some rules about durable medical equipment apply</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Emergency Room Visits <i>Only covered if the visit is for a true medical Emergency</i>	80% covered after Deductible	80% covered after Deductible
Hospice Care³	100% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Hospital – Inpatient³ or Outpatient	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Lab Work – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Maternity³ <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	Up to the 4 th day: 100% After the 4 th day: 80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible Not covered if related to weight management or bariatric surgery
Office Visit – General	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Office Visit – Specialist	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Preventive Care <i>Preventive Lab Work and X-rays included</i>	100% covered; not subject to the Deductible	Not covered

HEALTHCARE BENEFITS HANDBOOK

2019 HRA Medical Option		
	Network	Non-Network
Substance Use³ <ul style="list-style-type: none"> Inpatient Facility-Based Treatment Outpatient Care Treatment 	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Surgeon Services Assistant Surgeon Services Multiple Surgical Procedures <ul style="list-style-type: none"> 1st procedure 2nd procedure and subsequent procedures 	80% covered after Deductible 80% covered after Deductible 80% covered after Deductible 50% covered after Deductible	60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible
Therapies <i>30 combined network and non-network treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ³ <ul style="list-style-type: none"> Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services 	Covered with limitations	Not covered
X-Rays – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible

2 See "Eligible Expenses for Non-Network Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.

3 The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at 877-912-1820 or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

HEALTHCARE BENEFITS HANDBOOK

OOA HRA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 OOA HRA Medical Option	
Health Reimbursement Account (HRA) Dollars	
Employee Only	Up to \$700 can be earned through Delta Health Rewards ¹
Employee & Spouse	Up to \$1,400 can be earned through Delta Health Rewards ¹
Employee & Child(ren)	\$250 for children (plus up to \$1,100 can be earned through Delta Health Rewards) ¹
Family	\$250 for children (plus up to \$1,800 can be earned through Delta Health Rewards) ¹
1. You may earn these amounts to be deposited in your 2019 HRA based on actions completed under the Delta Health Rewards program from January 1, 2019 to November 30, 2019. To see what you have earned, go to Rally SM on myuhc.com or contact Delta Health Direct at 877-912-1820.	
Annual Deductible (HRA pays first) (medical expenses only)	
Employee Only	\$1,350
Employee & Spouse (<i>Individual/Family</i>)	\$1,350/\$2,700
Employee & Child(ren) (<i>Individual/Family</i>)	\$1,350/\$2,700
Family (<i>Individual/Family</i>)	\$1,350/\$4,000
Coinsurance (<i>% paid by plan</i>)	Plan pays 80% of the Eligible Expense ² after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use Benefits; Excludes Prescription Drug Benefits; Amount is in Addition to the Deductible)	
Employee Only	\$2,500
Employee & Spouse (<i>Individual/Family</i>)	\$2,500/\$3,750
Employee & Child(ren) (<i>Individual/Family</i>)	\$2,500/\$3,750
Family (<i>Individual/Family</i>)	\$2,500/\$5,000
Out-of-Pocket Maximum HRA maximums include Deductible, Annual Coinsurance Maximum and prescription drug Out-of-Pocket Maximum of \$1,250 for Employee Only coverage and \$2,500 for other coverage tiers	
Employee Only	\$5,100
Employee & Spouse (<i>Individual/Family</i>)	\$5,100/\$8,950
Employee & Child(ren) (<i>Individual/Family</i>)	5,100/\$8,950
Family (<i>Individual/Family</i>)	\$5,100/\$11,500
Lifetime Maximum Medical Benefit	No limit

HEALTHCARE BENEFITS HANDBOOK

2019 OOA HRA Medical Option

Behavioral Healthcare³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	<p>80% of the Eligible Expense² covered after Deductible No day limits apply</p> <p>80% of the Eligible Expense² covered after Deductible No day limits apply</p>
Chiropractic Care <i>20 visits per calendar year</i>	<p>80% of the Eligible Expense² covered after Deductible</p>
Durable Medical Equipment³ <i>Some rules about durable medical equipment apply</i>	<p>80% of the Eligible Expense² covered after Deductible</p>
Emergency Room Visits <i>Only covered if visit is for a true medical Emergency</i>	<p>80% of the Eligible Expense² covered after Deductible</p>
Hospice Care³	<p>100% of the Eligible Expense² covered after Deductible</p>
Hospital – Inpatient³ or Outpatient	<p>80% of the Eligible Expense² covered after Deductible</p>
Lab Work – Diagnostic	<p>80% of the Eligible Expense² covered after Deductible</p>
Maternity³ <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	<p>80% of the Eligible Expense² covered after Deductible</p>
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	<p style="text-align: center;">Up to the 4th day: 100%</p> <p>After the 4th day: 80% of the Eligible Expense² covered after Deductible</p>
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	<p>80% of the Eligible Expense² covered after Deductible</p>
Office Visit – General	<p>80% of the Eligible Expense² covered after Deductible</p>
Office Visit – Specialist	<p>80% of the Eligible Expense² covered after Deductible</p>
Preventive Care <i>– Preventive Lab Work and X-rays included</i>	<p>100% of the Eligible Expense² covered; not subject to the Deductible</p>
Substance Use³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	<p>80% of the Eligible Expense² covered after Deductible No day limits apply</p> <p>80% of the Eligible Expense² covered after Deductible No day limits apply</p>

HEALTHCARE BENEFITS HANDBOOK

2019 OOA HRA Medical Option	
Surgeon Services	80% of the Eligible Expense ² covered after Deductible
Assistant Surgeon Services	80% of the Eligible Expense ² covered after Deductible
Multiple Surgical Procedures	
• 1st procedure	80% of the Eligible Expense ² covered after Deductible
• 2nd procedure and subsequent procedures	50% of the Eligible Expense ² covered after Deductible
Therapies <i>30 treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	80% of the Eligible Expense ² covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ³	Covered with limitations
• Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services	
X-Rays – Diagnostic	80% of the Eligible Expense ² covered after Deductible

² See "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.

³ The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance Use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at **877-912-1820** or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

Prescription Drug Benefits — HRA Medical Options

When you enroll in an HRA Medical Option, you also receive prescription drug benefits.

Only prescriptions purchased at retail network pharmacies or through the mail order pharmacy administered by OptumRx™, a UnitedHealth Group Company, are covered under the HRA Medical Options. To find a network pharmacy, contact Delta Health Direct at **877-912-1820** or review the network pharmacy list at **myuhc.com**.

Under the HRA Medical Options, prescription drug expenses are handled separately from medical expenses. This means that prescription drug expenses are not paid from your HRA and do not count toward your annual medical Deductible or medical Annual Coinsurance Maximum.

Annual Pharmacy Out-of-Pocket Maximum

With the HRA Medical Options, there is an annual Pharmacy Out-of-Pocket Maximum that is separate from and in addition to the medical Annual Coinsurance Maximum. This means that the annual medical Deductible does not have to be satisfied before the prescription drug Coinsurance pays a benefit, and that prescription drug costs do not count toward the medical Annual Coinsurance Maximum or Deductible.

Once you reach your annual Pharmacy Out-of-Pocket Maximum (\$1,250 for individuals and \$2,500 for families), the plan pays 100% of your covered prescription drug expenses for the remainder of the plan year. (See the chart in this section.) If the family Pharmacy Out-of-Pocket Maximum is met before an individual family member reaches his or her own individual Pharmacy Out-of-Pocket Maximum, plan benefits apply for all family members.

Please Note Tier 4 drugs (see later in this “Prescription Drug Benefits – HRA Medical Options” section for information on Drug Tiers) are not covered by the HRA Medical Options. While you can receive a discounted price on these drugs if purchased at a network pharmacy, you will have to pay 100% of this discounted cost and, because they are not covered by the Plan, these expenses do not count toward any out-of-pocket expenses (i.e., your Pharmacy Out-of-Pocket Maximum).

Statins for Primary Prevention of Cardiovascular Disease

The United States Preventive Services Task Force (USPSTF) now recommends low-to moderate-dose intensity statins be provided for primary prevention of cardiovascular disease (CVD) in individuals at high risk. Certain statins will be covered at 100% (prior authorization may be required) for members who meet specific coverage criteria:

- Being age 40-75,
- Having one or more cardiovascular risk factors such as dyslipidemia, diabetes, hypertension or smoking, and
- Having a calculated 10-year risk of a cardiovascular event of 10% or greater. This will require universal lipid screening for this age group.

Statins to Be Covered at \$0 Cost Share

No Prior Authorization required (Ages 40-75)	lovastatin (generic Mevacor); all strengths
Prior Authorization required to confirm risk of cardiovascular disease	atorvastatin (generic Lipitor); 10 & 20 mg* simvastatin (generic Zocor); 5, 10, 20 & 40 mg*

* Only these strengths are available for \$0 cost share

Call Delta Health Direct at **877-912-1820** for more information.

Prescription Drug List

A Prescription Drug List (PDL) is a list of Food and Drug Administration (FDA) approved brand name and generic medications. The UHC pharmacy benefit provides coverage for a comprehensive list of prescription medications.

The UHC PDL Management Committee makes tier placement decisions to help ensure access to a wide range of medications. The Committee is composed of senior level physicians and business leaders who decide the tier placement of a particular prescription medication based on clinical information from the UHC Pharmacy and Therapeutics (P&T) Committee, as well as economic and financial considerations. The Committee looks at the overall healthcare value of a particular medication to balance the need for flexibility and choice for participants with an affordable pharmacy benefit.

Medications may be removed from the PDL or move to a higher tier up to two times per calendar year. Additionally, when a brand name medication becomes available as a generic, the tier status of the brand name medication and its corresponding generic are evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. Drugs not on the PDL are not covered expenses under the Plan. For the most current information on your pharmacy coverage, call Delta Health Direct at **877-912-1820** or visit **myuhc.com**.

You can view UHC's PDL on Benefits Direct, which is accessible on Deltanet. You can also access the drug list at **myuhc.com**.

Generic Substitution Program or “Member-Pays-the-Difference”

The pharmacy benefit includes a generic substitution program (referred to as “member-pays-the-difference”) that requires medications to be dispensed as generic drugs rather than brand name drugs if a chemically equivalent generic drug exists. The generic substitution will be dispensed by your pharmacist according to state law and your physician’s approval.

The Plan requires that if you or your physician choose to receive a brand name drug when a generic is available, you will be required to pay the brand Copay/Coinsurance plus 100% of the difference in the cost of the two drugs. This “member-pays-the-difference” amount (or ancillary charge) counts toward your annual Pharmacy Out-of-Pocket Maximum but not your annual Deductible. Once your annual Pharmacy Out-of-Pocket Maximum has been met, the Plan will pay 100% of the cost of the brand name drug for the rest of the benefit plan year.

Prior Authorization

Before certain prescription Drugs are dispensed to you, they must receive prior authorization approval from UnitedHealthcare. Prior authorization is a formal process that your doctor goes through. He or she must give a medical reason why they are prescribing that medicine and UnitedHealthcare determines if the prescription drug is:

- A Covered Service
- Medically Necessary
- Not experimental, investigational or unproven

This process helps the Plan keep costs down for everyone by having doctors prescribe appropriate medications based on members’ individual medical conditions.

If prior authorization is required for your prescription drug and is not approved, you will have to pay 100% of the price, and these expenses do not count towards your annual Pharmacy Out-Of-Pocket Maximum since it is not covered by the Plan.

To determine if a prescription drug requires prior authorization, check UHC’s Prescription Drug List (PDL) on Benefits Direct. You can also access the PDL at myuhc.com or call Delta Health Direct at **877-912-1820**.

Specialty Pharmacy Program

Specialty medications to treat certain chronic illness are only covered by the Specialty Pharmacy Program rather than the retail or mail order programs. The mandatory Specialty Pharmacy Program is designed to better manage the cost and quality of services available to users of these high-cost medications. If you use a specialty medication, UHC will notify you directly with details regarding this program. If you choose to obtain the specialty medication at a retail or mail order pharmacy other than the named Specialty Pharmacy, the medication is not covered by the Plan and you will pay the full cost. It also will not count toward your Deductible or Annual Coinsurance Maximum since it is not covered by the Plan.

Select Designated Pharmacy Program

The Select Designated Pharmacy Program administered by OptumRx™ applies to a select number of high-cost, brand-name drugs that are covered by the plan. This program offers the impacted participants with cost-saving options, including receiving the drug you were prescribed by mail order delivery or receiving a lower-cost alternative drug at your retail pharmacy or by mail order delivery. The program also helps members understand their medications and savings options through the use of letters, point-of-sale messaging at the retail pharmacy, and outgoing calls. If you use a medication that is part of the Select Designated Pharmacy Program, UHC will notify you directly with details regarding this program.

Refill and Save Program

People who take their medication as prescribed are less likely to need additional medication down the road. Members who fill their prescription for a qualifying Refill and Save Program medication as prescribed are given a \$20 savings off their usual Copay or Coinsurance. For those refilling by mail order, they will receive an average reduction of \$50 on their Copay or Coinsurance based on a 90-day supply. This program is automatic for those taking a qualifying prescription.

Members who refill these qualifying medications on a regular basis will receive a lower Copay or Coinsurance at the pharmacy; members do not have to sign up to receive the benefits. To qualify, members must refill their prescription within 30 days of the day it was scheduled to run out. For example, if the prescription were written for 30 days, the member would have that 30 days plus a 30-day grace period (for a total of 60 days) to refill the prescription in order to qualify.

Call Delta Health Direct at **877-912-1820** for more information.

Drug Tiers

Prescription drugs costs are based on their tier. There are four tiers. Generally, Tier 1 is made up of generics and other low-cost drugs. Tiers 2-4 are typically made up of higher cost and brand-name drugs. Tier 4 medications are not covered by the Plan.

Tier 1 drugs are available for a flat \$10 Copay for retail or \$25 for mail order — or lower, if the actual cost is less than \$10/\$25.

When you purchase a Tier 2 or Tier 3 drug, you pay Coinsurance — up to 20% of the cost of the drug. The plan covers the remainder. However, set minimum and maximum amount limits are in place for each of these three tiers.

These minimum and maximum amounts vary depending on which tier the drug falls under.

- When 20% of the cost of the drug is LESS than the minimum limit, you pay the minimum limit (\$30 Tier 2 or \$50 Tier 3 for retail; \$75 Tier 2 or \$125 Tier 3 for mail order)
- When 20% of the cost of the drug is MORE than the minimum limit, but LESS than the maximum limit, you pay the 20% Coinsurance
- When 20% of the cost of the drug is MORE than the maximum limit, you pay the maximum limit (\$75 Tier 2 or \$125 Tier 3 for retail; \$175 Tier 2 or \$300 Tier 3 for mail order)
- When the total cost of the is LESS than the minimum limit, you pay the total cost of the prescription

Your Copays or Coinsurance for any prescription drugs do not count toward your annual medical Deductible or medical Annual Coinsurance Maximum.

HEALTHCARE BENEFITS HANDBOOK

Since a Tier 4 drug is not covered by the Plan, you pay 100% of the cost of the drug, though you may receive a discounted price due to your HRA Medical Plan coverage. The costs you pay for drugs in Tier 4 do not apply to the annual Pharmacy Out-of-Pocket Maximum since they are not covered by the Plan.

Visit the “Price a Medication” tool on myuhc.com to find out on which tier your drug is classified. Note that prescription drug tier information is updated quarterly by UHC.

Prescription Drug Benefit Overview — HRA Medical Options

2019 Prescription Drug Benefits — HRA Medical Options*		
Only prescriptions purchased at network pharmacies or the mail order pharmacy are covered		
	Retail	Mail Order
Tier 1	\$10 Copay	\$25 Copay
Tier 2	20% (\$30 min/\$75 max)	20% (\$75 min/\$175 max)
Tier 3	20% (\$50 min/\$125 max)	20% (\$125 min/\$300 max)
Tier 4**	Not covered	Not covered

* Mandatory generics apply. This program requires that prescriptions be filled with the generic product, if one is available. If you purchase a brand name drug instead of a chemically equivalent generic, you will be required to pay the brand Copay/Coinsurance plus 100% of the difference in the cost of the two drugs – the ancillary charge. See the “Generic Substitution Program or Member-Pays-the-Difference” earlier in this section for details on how your Deductible and Out-of-Pocket Maximum may be impacted by this ancillary charge. As of December 1, 2017, select statins are covered at \$0 cost-share for members who meet specific coverage criteria under new Affordable Care Act regulations. See “Statins for Primary Prevention of Cardiovascular Disease” earlier in this section for details.

** Since Tier 4 drugs are not covered by the Plan, you pay 100% of the cost of the drug, though you may receive a discounted price due to your HRA Medical Plan coverage. The costs you pay for drugs in Tier 4 do not apply to the annual Pharmacy Out-of-Pocket Maximum since they are not covered by the Plan.

Note: The 2019 Prescription Drug List (PDL) can be found on Benefits Direct. You can also access the drug list at myuhc.com.

For Pharmacy Program Details

To find a network pharmacy, get prescription drug information or request a mail order claim form, you may contact Delta Health Direct at **877-912-1820**. You also can view the network pharmacy list and the PDL at myuhc.com.

How the HSA Medical Options Work

Delta's HSA Medical Options manage healthcare benefits very differently from traditional healthcare plans. Plus, they are funded differently from the HRA Medical Options.

Read on to learn how the following features work under the HSA Medical Options:

- Health Savings Account funded by you
- Annual Deductible
- Coinsurance
- Annual Coinsurance Maximum
- Behavioral health and substance use benefits
- Prescription drug benefits

Health Savings Account Funded by You and by Delta

Your HSA Contributions

If you enroll in an HSA Medical Option, you have high-deductible health plan coverage that may make you eligible to contribute income tax-free (in most states) to a Health Savings Account (HSA).

If you set up an HSA with Optum Bank, a UHC affiliate, you can make contributions through Delta pre-tax payroll deductions. You can change your HSA contribution amount at any time during the year and are not required to fund your Optum Bank HSA through equal pay period installments throughout the year. This means that you can elect higher pay period contributions to meet your annual goal amount sooner.

If you go off active pay status during the year and miss two payroll deductions, your payroll deductions automatically cease. However, you can continue contributing to your Optum Bank HSA by directly depositing funds into your account. You are responsible for monitoring your applicable annual limit to make sure you do not over-contribute.

If you choose to directly deposit the funds and are otherwise eligible, you may take a deduction on your income tax return for the year.

If you set up an HSA at a different financial institution, you must deposit the funds into that account directly and take any appropriate deduction on your taxes. HSA payroll deductions are not available for financial institutions other than Optum Bank.

The Health Savings Account (HSA) is not an employee benefit plan sponsored or maintained by Delta. An individual who participates in an HSA Medical Option is participating in a high-deductible health plan sponsored by Delta, and accordingly, may be eligible to establish an HSA account for his or her own benefit. The Optum Bank HSA, to which employee payroll deductions may be made, or any other HSA to which a participant contributes, is not a Delta-sponsored plan, but instead is an individual arrangement set up by the employee. A participant in an HSA Medical Option has the choice of any HSA product he or she wishes to use, and is not required to set up an HSA with Optum Bank or any other financial institution.

For information about the Optum Bank HSA, you can view the UHC pre-enrollment website prior to Annual Open Enrollment at welcometouhc.com/delta. When you log on, enter Username *delta* and Password *delta* (both lowercase). At other times, you can access the Optum Bank HSA website at <https://enrollhsa.optumbank.com/enrollment#/?group=226310>.

Delta Health Rewards and Your HSA

If you enroll in the Gold HSA Medical Option, Silver HSA Medical Option, Bronze HSA Medical Option or OOA Gold HSA Medical Option for 2019 and have an Optum Bank HSA, the amount of HSA contributions you receive for the year is based on the coverage tier you elect and the amount that you and your Spouse earn under the Delta Health Rewards program during the year. For a list of the health actions and dollars that can be earned, see "Delta Health Rewards Program" under "Medical Plan Programs" earlier in this "Medical Benefits" section. Delta Health Rewards dollars are deposited to your Optum Bank HSA in real time and available during the same plan year that they were earned.

The amount of the Company contribution available for 2019 for each health action is intended to offset the deductibles that apply to the HSA Medical Options for 2019. The Delta Health Rewards dollars contributed to your Optum Bank HSA by Delta as well as any child funding or HSA contributions that you make (including pre-tax deductions from your paycheck) apply towards the maximum annual HSA contribution limit set under federal tax law.

Note: You must have an open Optum Bank HSA account. If you do not open an Optum Bank HSA or consent to allow your Optum Bank HSA to be opened during Annual Open Enrollment (or at other times), Delta will not be able to deposit the Delta Health Rewards that you may earn or for child funding, if eligible.

How Much You May Contribute to an HSA

For 2019, if you are an eligible HSA participant, you may contribute the following maximums set by law:

- Up to \$3,500* annually for employee only coverage
- Up to \$7,000* annually for employee & spouse, employee & child(ren) or family coverage
- Plus an additional \$1,000 if you are age 55 or over and eligible to make catch-up contributions

Eligible HSA contributions are taken pre-tax through payroll deductions (for the Optum Bank HSA only) or are permitted deductions on your income tax return. Either of these contribution options reduce your taxable income. Maximum HSA contribution limits are mandated by federal law and may be adjusted annually.

2019 HSA Contribution Amounts for Delta Couples

If both you and your Spouse are employed by Delta, you may elect the full \$3,500* Employee Only/\$7,000* Family HSA contribution. It is your responsibility to determine the appropriate split so you do not exceed the IRS family limit.

* The annual HSA contributions that you make, as well as Delta Health Rewards dollars you earn and child contributions to your Optum Bank HSA by Delta, apply toward this 2019 maximum annual HSA contribution limit.

Using HSA Dollars

You choose how and when to use these account dollars. Because you make the contributions to your HSA, you own the account. If you have qualified expenses, you may use the dollars in your HSA to pay these expenses. You can opt to use your HSA dollars for qualified expenses each year, or you can decide not to withdraw your HSA dollars and allow funds to accumulate in the account. To access funds in your HSA at Optum Bank, visit myuhc.com or www.optumbank.com.

Planning Note: *Over-the-counter medications are only eligible for reimbursement from an HSA if they are prescribed by a doctor.* This means that any non-prescribed over-the-counter medications are not eligible for reimbursement.

The HSA Is Portable

Because the HSA is your individual account, if you change employers or retire, your HSA funds stay in the account, and the account stays with you. These funds can even be used for eligible retiree medical expenses.

HSA Tax Rules

You should learn the many tax rules that govern the use of HSAs and monitor your contributions and qualified expenses. For more information about HSAs and the tax rules that apply to them, review the material in Publication 969 at www.irs.gov. You also may consider consulting with a tax advisor.

Opening an HSA with Optum Bank

If you do not open an Optum Bank HSA or consent to allow your Optum Bank HSA to be opened during Annual Open Enrollment (or at other times), Delta will not be able to deposit the Delta Health Rewards that you may earn or for child funding, if eligible.

For information on the Optum Bank HSA (including investment options, rules, fees and deposit instructions) and/or to set up an Optum Bank HSA, visit the Optum Bank website. Refer to the "Enrolling for Healthcare and Flexible Spending Account Benefits" section of this handbook for details about setting up an HSA account and accessing the Optum Bank website.

If You Are Enrolled in a Delta HSA Medical Option and Change to a Delta HRA Medical Option

If you change from a Delta HSA Medical Option to a Delta HRA Medical Option, any unused HSA balance at the end of the prior year remains in your HSA. You will be responsible for the monthly HSA service fee charged by Optum Bank as long as your HSA account remains open and you are not enrolled in a Delta HSA Medical Option.

If You Are Enrolled in a Delta HRA Medical Option and Change to a Delta HSA Medical Option (Post-Deductible HRA)

If you are enrolled in an HRA Medical Option and choose to enroll in one of the HSA Medical Options during a future enrollment period, any unused balance in your HRA will be converted to a Post-Deductible HRA that can be used in connection with the HSA Medical Option. See “How the HRA Medical Options Work” for more information on the Post-Deductible HRA.

Here is how the Post-Deductible HRA works in connection with a Delta HSA Medical Option:

- First, you must meet the deductible as determined by your HSA Medical Option, or if less, the high-deductible health plan deductible amount specified by the Internal Revenue Code (for 2019, this amount is \$1,350 for employee-only coverage or \$2,700 for all other coverage categories, for example, employee + children or family coverage). Note: If you are enrolled in any other coverage category other than employee only, the entire IRS required minimum family deductible of \$2,700 must be met in full before your Post-Deductible HRA will start paying any benefits. It does not start paying for an individual once they meet the individual deductible regardless of which HSA plan they are in.
- After you have met this deductible, but before you reach your Annual Coinsurance Maximum, when you have a covered expense (including a prescription drug expense), the full cost of the expense (discounted by Network Providers) is automatically deducted from your Post-Deductible HRA balance
- Covered expenses are paid by your Post-Deductible HRA until either your HSA Medical Option Annual Coinsurance Maximum (when the plan begins to pay 100% for the remainder of the year) is met or the Post-Deductible HRA balance is depleted
- Once your Post-Deductible HRA is depleted and before your Annual Coinsurance Maximum is reached, you can choose to use your Health Savings Account or Limited Purpose Flexible Spending Account for reimbursement of your 20% Coinsurance amount for covered expenses. See “How the HSA Medical Options Work” for information on using your HSA dollars

Annual Deductible

The annual Deductible is the dollar amount of covered expenses that you must pay before the plan begins to pay benefits each calendar year. With the HSA Medical Options, this amount is higher than with traditional preferred provider organization (PPO) or point-of service (POS) plans.

If you are enrolled in the Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, there are two separate Deductible amounts — one for network services and another for non-network services. The Deductible for non-network services is higher than that for network services. If you are enrolled in the OOA Gold HSA or Retiree & Survivor Bronze OOA HSA, you have one Deductible to meet, regardless of whether you receive services through the UHC network.

Your Copays/Coinsurance for Preventive Drugs do not count toward your Deductible since the plan pays part of the cost of these drugs before your Deductible is met. However, the Copays and

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Coinsurance amounts do count toward your Annual Coinsurance Maximum. Your Coinsurance for all other covered prescription drugs does count toward your Deductible.

Any amounts in excess of the Eligible Expense are not covered by the Plan and therefore are not applied to the Deductible. You must always pay 100% of these excess amounts.

2019 HSA Medical Option Annual Deductibles							
	Gold HSA Medical Option		Silver HSA Medical Option		Bronze HSA Medical Option		OOA Gold HSA Medical Option
	Network	Non-Network	Network	Non-Network	Network	Non-Network	
Employee Only	\$1,350	\$2,700	\$2,700	\$5,400	\$3,100	\$6,200	\$1,350
Employee & Spouse	\$2,700*	\$5,400*	\$2,700/ \$4,000 (Individual/ Family)	\$5,400/ \$8,000 (Individual/ Family)	\$3,100/ \$4,650 (Individual/ Family)	\$6,200/ \$9,300 (Individual/ Family)	\$2,700*
Employee & Child(ren)	\$2,700*	\$5,400*	\$2,700/ \$4,000 (Individual/ Family)	\$5,400/ \$8,000 (Individual/ Family)	\$3,100/ \$4,650 (Individual/ Family)	\$6,200/ \$9,300 (Individual/ Family)	\$2,700*
Family	\$2,700*	\$5,400*	\$2,700/ \$7,900 (Individual/ Family)	\$5,400/ \$15,800 (Individual/ Family)	\$3,100/ \$9,300 (Individual/ Family)	\$6,200/ \$18,600 (Individual/ Family)	\$2,700*

* There is not an individual Deductible component for this level of coverage in the Gold HSA Medical Option or OOA Gold HSA Medical Option. This means that the entire amount of the Deductible must be met by any combination of claims for you and your covered family members before the plan begins to pay benefits for any of the covered family members for the calendar year.

2019 HSA Medical Option Annual Deductibles			
	Retiree & Survivor Bronze HSA Medical Option		Retiree & Survivor Bronze OOA HSA Medical Option
	Network	Non-Network	
Employee Only	\$5,200	\$10,400	\$5,200
Employee & Spouse <i>(Individual/Family)</i>	\$5,200/\$7,800	\$10,400/\$15,600	\$5,200/\$7,800
Employee & Child(ren) <i>(Individual/Family)</i>	\$5,200/\$7,800	\$10,400/\$15,600	\$5,200/\$7,800
Family <i>(Individual/Family)</i>	\$5,200/\$13,100	\$10,400/\$26,200	\$5,200/\$13,100

How Family Members Meet the Deductible: Gold HSA or OOA Gold HSA

There is not an individual deductible component for the employee + spouse, employee+ children and family coverage categories in the Gold HSA Medical Option or OOA Gold HSA Medical Option. This means that the entire amount of the \$2,700 network/\$5,400 non-network deductible, or \$2,700 deductible for the OOA Gold HSA Medical Option, must be met before the plan begins to pay benefits for the calendar year for any family member. The deductible can be met by one family member or a combination of family members.

For example, an employee, Spouse and three children are enrolled in family coverage under the Gold HSA Medical Option. The amounts that are paid by each family member toward the annual Deductible accumulate. Then, once the expenses of all of the family members combined meets the family Deductible, the plan begins to pay eligible expenses for all covered family members at the appropriate Coinsurance rate (see chart in the "Coinsurance" section).

How Family Members Meet the Deductible: Silver HSA, Bronze HSA, Retiree & Survivor Bronze HSA, and Retiree & Survivor Bronze OOA HSA

Unless you are enrolled in employee only coverage, no one family member is required to meet the overall plan Deductible.

For employee & spouse, employee & child(ren) and family levels of coverage, a family member is only required to meet his or her individual Deductible of \$2,700 network/\$5,400 non-network for the Silver HSA Medical Option, \$3,100 network/\$6,200 non-network for the Bronze HSA Medical Option, \$5,200 network/\$10,400 non-network for the Retiree & Survivor Bronze HSA Medical Option, or \$5,200 for the Retiree & Survivor Bronze OOA HSA Medical Option before plan benefits and Coinsurance apply.

Once an enrolled family member meets his or her individual Deductible, the plan begins to pay his or her eligible expenses at the appropriate Coinsurance rate (see chart in the "Coinsurance" section). Then, Deductible-eligible expenses paid by any combination of the other family members will accumulate to meet the combined family Deductible. If the family Deductible is met before an individual family member reaches his or her own individual Deductible, plan benefits and Coinsurance apply for all family members.

Paying the Deductible

You may use the funds in your HSA to help pay your annual Deductible if you desire. You pay the full cost of medical services (which are discounted in the network) up to the annual Deductible. If eligible, you may make a claim for reimbursement from your HSA directly with your HSA trustee. The plan does not process the HSA reimbursements.

Remember, if you were previously enrolled in a Delta HRA Medical Option, you may also have a Post-Deductible HRA that can be used in conjunction with your HSA Medical Option. Once you meet the annual Deductible as determined by your HSA Medical Option, or if less, the high-deductible health plan deductible amount specified by the Internal Revenue Code, covered expenses are paid from your Post-Deductible HRA until either your HSA Medical Option Coinsurance Maximum is met or your Post-Deductible HRA balance is depleted. See "If You Are Enrolled in a Delta HRA Medical Option and Change to a Delta HSA Medical Option (Post-Deductible HRA)" earlier in this section for more information.

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Coinsurance

Once you and/or your dependents have met your annual Deductible, you share expenses with the plan. Your portion of these expenses is called your Coinsurance.

The Gold HSA Medical Option, Silver HSA Medical Option and Bronze HSA Medical Option generally pay 80% of the cost of Network Charges while you pay the remaining 20%. For Non-Network Charges, the Gold HSA Medical Option, Silver HSA Medical Option and Bronze HSA Medical Option generally pay 60% of the Eligible Expense after the non-network Deductible is met.

The OOA Gold HSA Medical Option generally pays for 80% of the Eligible Expense for Covered Services, while you pay the remaining 20%.

The Retiree & Survivor Bronze HSA Medical Option generally pays 70% of the cost of Network Charges while you pay the remaining 30%. For Non-Network Charges, the Retiree & Survivor Bronze HSA Medical Option generally pays 50% of the Eligible Expense after the non-network Deductible is met.

The Retiree & Survivor Bronze OOA Medical Option generally pays for 70% of the Eligible Expense for Covered Services, while you pay the remaining 30%.

2019 HSA Medical Option Coinsurance			
	Gold HSA Medical Option Silver HSA Medical Option Bronze HSA Medical Option		OOA Gold HSA Medical Option
	Network	Non-Network	
You Pay	20%	40%*	20%**
Plan Pays	80%	60%*	80%**

* Based on Eligible Expenses (see "Eligible Expenses for Non-Network Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined). In addition to Coinsurance, you also are responsible for 100% of the difference between billed charges and the Eligible Expense. The plans do not cover this difference, and these amounts do not apply to the Deductible or Annual Coinsurance Maximum.

** Based on Eligible Expenses (see "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined). In addition to the Coinsurance, you are responsible for 100% of the difference between billed charges and the Eligible Expense. The plans do not cover this difference, and these amounts do not apply to the Deductible or Out-of-Pocket Maximum.

2019 HSA Medical Option Coinsurance			
	Retiree & Survivor Bronze HSA Medical Option		Retiree & Survivor Bronze OOA HSA Medical Option
	Network	Non-Network	
You Pay	30%	50%*	30%**
Plan Pays	70%	50%*	70%**

* Based on Eligible Expenses (see "Eligible Expenses for Non-Network Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined). In addition to Coinsurance, you also are responsible for 100% of the difference between billed charges and the Eligible Expense. The plans do not cover this difference, and these amounts do not apply to the Deductible or Annual Coinsurance Maximum.

** Based on Eligible Expenses (see "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined). In addition to the Coinsurance, you are responsible for 100% of the difference between billed charges and the Eligible Expense. The plans do not cover this difference, and these amounts do not apply to the Deductible or Out-of-Pocket Maximum.

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Annual Coinsurance Maximum

With the HSA Medical Options, the most you would be required to spend out of pocket on Coinsurance in any year for covered medical expenses is known as the Annual Coinsurance Maximum. Once your Coinsurance payments reach this dollar limit, the plan pays 100% for Covered Services for the remainder of the plan (calendar) year. The Annual Coinsurance Maximum is in addition to the Deductible.

There are separate Annual Coinsurance Maximums for network and non-network services received under the Gold HSA Medical Option, Silver HSA Medical Option, Bronze HSA Medical Option and Retiree & Survivor Bronze HSA Medical Option. The OOA Gold HSA Medical Option and the Retiree & Survivor Bronze OOA HSA Medical Option each have their own Annual Coinsurance Maximums.

Any amounts in excess of the Eligible Expense are not covered by the Plan and not applied to the Annual Coinsurance Maximum. You, not the Plan, must always pay 100% of these excess amounts.

2019 HSA Medical Option Annual Coinsurance Maximums (Amount is in Addition to the Deductible)							
	Gold HSA Medical Option		Silver HSA Medical Option		Bronze HSA Medical Option		OOA Gold HSA Medical Option
	Network	Non-Network	Network	Non-Network	Network	Non-Network	
Employee Only	\$2,500	\$5,000	\$2,500	\$5,000	\$3,300	\$6,600	\$2,500
Employee & Spouse <i>(Individual/Family)</i>	\$2,500/ \$3,750	\$5,000/ \$7,500	\$2,500/ \$3,750	\$5,000/ \$7,500	\$3,300/ \$4,950	\$6,600/ \$9,900	\$2,500/ \$3,750
Employee & Child(ren) <i>(Individual/Family)</i>	\$2,500/ \$3,750	\$5,000 \$7,500	\$2,500/ \$3,750	\$5,000/ \$7,500	\$3,300/ \$4,950	\$6,600/ \$9,900	\$2,500/ \$3,750
Family <i>(Individual/Family)</i>	\$2,500/ \$5,000	\$5,000/ \$10,000	\$2,500/ \$5,000	\$5,000/ \$10,000	\$3,300/ \$3,800	\$6,600/ \$7,600	\$2,500/ \$5,000

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2019 HSA Medical Option Annual Coinsurance Maximums (Amount is in Addition to the Deductible)			
	Retiree & Survivor Bronze HSA Medical Option		Retiree & Survivor Bronze OOA HSA Medical Option
	Network	Non-Network	
Employee Only	\$1,200	\$2,400	\$1,200
Employee & Spouse <i>(Individual/Family)</i>	\$1,200/\$1,800	\$2,400/\$3,600	\$1,200/\$1,800
Employee & Child(ren) <i>(Individual/Family)</i>	\$1,200/\$1,800	\$2,400/\$3,600	\$1,200/\$1,800
Family <i>(Individual/Family)</i>	\$1,200/\$0	\$2,400/\$0	\$1,200/\$0

How Family Members Meet the Annual Coinsurance Maximum

For employee & spouse, employee & child(ren) and family levels of coverage, a family member is only required to meet his or her individual Annual Coinsurance Maximum before the plan begins paying 100% for that one family member.

Example: An individual who has family coverage under the Gold HSA Medical Option would reach the network Annual Coinsurance Maximum once his or her medical expenses for network Covered Services add up to \$2,500 for the year. This individual's covered network medical expenses would then be paid by the plan at 100% for the rest of the year. The individual would not have to wait until the entire family's covered network expenses reach \$5,000 for this to happen.

Place of Service Surcharge

The Gold HSA, Silver HSA, Bronze HSA and Retiree & Survivor Bronze HSA Medical Options include a \$250 "place of service surcharge" that applies to outpatient Major Diagnostics – CT scans, PET scans, MRIs, MRAs, nuclear medicine and major diagnostic services – if these procedures are not done at a free-standing facility. This \$250 place of service surcharge also applies to outpatient surgeries that are performed in a hospital. This surcharge may be avoided by making sure that the facility where these outpatient services are received is independently run, not managed, billed or otherwise associated with a hospital. This surcharge does not apply to labs and X-rays unless they are done in conjunction with an outpatient surgery at a hospital.

This \$250 place of service surcharge applies to Network and Non-Network Services and must be paid in addition to the annual Deductible and Coinsurance amount. However, place of service surcharges that you pay count towards the Annual Out-of-Pocket Maximum and will not apply once the Annual Out-of-Pocket Maximum is reached.

For assistance in locating a free-standing facility, please contact Delta Health Direct at **877-912-1820**.

Behavioral Health and Substance Use Benefits

Your mental health is just as important as your physical health. Therefore, when you enroll in the HSA Medical Options, you automatically receive certain behavioral health benefits and substance use (BH/SU) treatment benefits through OptumHealth Behavioral Solutions. You may seek behavioral health services either through a Network or Non-Network Provider.

Costs for behavioral health services apply toward your HSA Medical Option's Deductibles and Annual Coinsurance Maximum.

Prior Authorization from OptumHealth Behavioral Solutions is required for certain BH/SU services. Be sure to read the "When You Must Notify UHC or OptumHealth Behavioral Solutions" section earlier in this "Medical Benefits" section for details.

For full coverage details about BH/SU services, refer to the section, "What the Delta Medical Plans Cover," which appears later in this "Medical Benefits" section of this handbook.

Prescription Drug Benefits

Prescription drug benefits for both retail and mail order prescriptions are included with the HSA Medical Options. UnitedHealthcare administers the program, with the mail order pharmacy administered by OptumRx™, a UnitedHealth Group Company.

Your out-of-pocket expenses will vary based on the type of prescription you are filling:

- Preventive Drugs (e.g., some high blood pressure medications, some cholesterol medications, etc.) are available based on a tiered cost structure. You do not need to meet your Deductible before the plan pays part of the cost for these Preventive Drugs and, for that reason, they do not count toward your Deductible. However, your share of the cost for these Preventive Drugs counts toward your Annual Coinsurance Maximum
- For all other covered prescription drugs, you pay the full discounted cost until you reach the annual medical plan Deductible and you pay 20% of the full discounted cost up the Annual Coinsurance Maximum

Full details about the prescription drug benefits appear later in this section.

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Gold HSA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 Gold HSA Medical Option		
	Network	Non-Network
Delta-Provided Health Savings Account (HSA) Dollars		
Employee Only	Up to \$700 can be earned through Delta Health Rewards ¹	
Employee & Spouse	Up to \$1,400 can be earned through Delta Health Rewards ¹	
Employee & Child(ren)	\$250 automatic for children (plus up to \$1,100 can be earned through Delta Health Rewards) ¹	
Family	\$250 automatic for children (plus up to \$1,800 can be earned through Delta Health Rewards) ¹	
<small>¹ You may earn these amounts to be deposited in your 2019 HSA based on actions completed under the Delta Health Rewards program from January 1, 2019 to November 30, 2019. To see what you have earned, go to RallySM on myuhc.com or contact Delta Health Direct at 877-912-1820.</small>		
Annual Deductible		
Employee Only	\$1,350	\$2,700
Employee & Spouse	\$2,700	\$5,400
Employee & Child(ren)	\$2,700	\$5,400
Family	\$2,700	\$5,400
Coinsurance (<i>% paid by plan</i>)	Plan pays 80% after Deductible	Plan pays 60% of the Eligible Expense ² after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use and Prescription Drug Benefits; Amount is in Addition to the Deductible)		
Employee Only	\$2,500	\$5,000
Employee & Spouse (<i>Individual/Family</i>)	\$2,500/\$3,750	\$5,000/\$7,500
Employee & Child(ren) (<i>Individual/Family</i>)	\$2,500/\$3,750	\$5,000/\$7,500
Family (<i>Individual/Family</i>)	\$2,500/\$5,000	\$5,000/\$10,000
Out-of-Pocket Maximum		
HSA maximum include Deductible and Annual Coinsurance Maximum		
Employee Only	\$3,850	\$7,700
Employee & Spouse (<i>Individual/Family</i>)	\$5,200/\$6,450	\$10,400/\$12,900
Employee & Child(ren) (<i>Individual/Family</i>)	\$5,200/\$6,450	\$10,400/\$12,900
Family (<i>Individual/Family</i>)	\$5,200/\$7,700	\$10,400/\$15,400
Lifetime Max. Medical Benefit	No limit	

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2019 Gold HSA Medical Option		
	Network	Non-Network
Behavioral Healthcare³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Chiropractic Care <i>20 visits per calendar year</i>	80% covered after Deductible	Not covered
Durable Medical Equipment³ <i>Some rules about durable medical equipment apply</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Emergency Room Visits <i>Only covered if the visit is for a true medical Emergency</i>	80% covered after Deductible	80% covered after Deductible
Hospice Care³	100% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Hospital – Inpatient³ or Outpatient	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Lab Work – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Maternity³ <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	Up to the 4 th day: 100% After the 4 th day: 80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible Not covered if related to weight management or bariatric surgery
Office Visit – General	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Office Visit – Specialist	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Preventive Care <i>Preventive Lab Work and X-rays included</i>	100% covered; not subject to the Deductible	Not covered

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2019 Gold HSA Medical Option		
	Network	Non-Network
Substance Use³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Surgeon Services Assistant Surgeon Services Multiple Surgical Procedures <ul style="list-style-type: none"> • 1st procedure • 2nd procedure and subsequent procedures 	80% covered after Deductible 80% covered after Deductible 80% covered after Deductible 50% covered after Deductible	60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible
Therapies <i>30 combined network and non-network treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ³ <ul style="list-style-type: none"> • Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services 	Covered with limitations	Not covered
X-Rays – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible

2 See "Eligible Expenses for Non-Network Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.

3 The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at 877-912-1820 or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

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Silver HSA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 Silver HSA Medical Option		
	Network	Non-Network
Delta-Provided Health Savings Account (HSA) Dollars		
Employee Only	Up to \$700 can be earned through Delta Health Rewards ¹	
Employee & Spouse	Up to \$1,400 can be earned through Delta Health Rewards ¹	
Employee & Child(ren)	\$250 automatic for children (plus up to \$1,100 can be earned through Delta Health Rewards) ¹	
Family	\$250 automatic for children (plus up to \$1,800 can be earned through Delta Health Rewards) ¹	
¹ You may earn these amounts to be deposited in your 2019 HSA based on actions completed under the Delta Health Rewards program from January 1, 2019 to November 30, 2019. To see what you have earned, go to Rally SM on myuhc.com or contact Delta Health Direct at 877-912-1820.		
Annual Deductible		
Employee Only	\$2,700	\$5,400
Employee & Spouse (Individual/Family)	\$2,700/\$4,000	\$5,400/\$8,000
Employee & Child(ren) (Individual/Family)	\$2,700/\$4,000	\$5,400/\$8,000
Family (Individual/Family)	\$2,700/\$7,900	\$5,400/\$15,800
Coinsurance (% paid by plan)	Plan pays 80% after Deductible	Plan pays 60% of the Eligible Expense ² after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use and Prescription Drug Benefits; Amount is in Addition to the Deductible)		
Employee Only	\$2,500	\$5,000
Employee & Spouse (Individual/Family)	\$2,500/\$3,750	\$5,000/\$7,500
Employee & Child(ren) (Individual/Family)	\$2,500/\$3,750	\$5,000/\$7,500
Family (Individual/Family)	\$2,500/\$5,000	\$5,000/\$10,000
Out-of-Pocket Maximum		
HSA maximums include Deductible and Annual Coinsurance Maximum		
Employee Only	\$5,200	\$10,400
Employee & Spouse (Individual/Family)	\$5,200/\$7,750	\$10,400/\$15,500
Employee & Child(ren) (Individual/Family)	\$5,200/\$7,750	\$10,400/\$15,500
Family (Individual/Family)	\$5,200/\$12,900	\$10,400/\$25,800

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2019 Silver HSA Medical Option		
	Network	Non-Network
Lifetime Max. Medical Benefit	No limit	
Behavioral Healthcare³ • Inpatient Facility-Based Treatment • Outpatient Care Treatment	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Chiropractic Care <i>20 visits per calendar year</i>	80% covered after Deductible	Not covered
Durable Medical Equipment³ <i>Some rules about durable medical equipment apply</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Emergency Room Visits <i>Only covered if the visit is for a true medical Emergency</i>	80% covered after Deductible	80% covered after Deductible
Hospice Care³	100% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Hospital – Inpatient³ or Outpatient	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Lab Work – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Maternity³ <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	Up to the 4 th day: 100% After the 4 th day: 80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible Not covered if related to weight management or bariatric surgery
Office Visit – General	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Office Visit – Specialist	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Preventive Care <i>Preventive Lab Work and X-rays included</i>	100% covered; not subject to the Deductible	Not covered

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2019 Silver HSA Medical Option		
	Network	Non-Network
Substance Use³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Surgeon Services Assistant Surgeon Services Multiple Surgical Procedures <ul style="list-style-type: none"> • 1st procedure • 2nd procedure and subsequent procedures 	80% covered after Deductible 80% covered after Deductible 80% covered after Deductible 50% covered after Deductible	60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible
Therapies <i>30 combined network and non-network treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ³ <ul style="list-style-type: none"> • Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services 	Covered with limitations	Not covered
X-Rays – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible

2 See "Eligible Expenses for Non-Network Benefits" earlier in this Medical Section for details on how the Eligible Expense is determined.

3 The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at **877-912-1820** or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

HEALTHCARE BENEFITS HANDBOOK

Bronze HSA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 Bronze HSA Medical Option		
	Network	Non-Network
Delta-Provided Health Savings Account (HSA) Dollars		
Employee Only	Up to \$700 can be earned through Delta Health Rewards ¹	
Employee & Spouse (<i>Individual/Family</i>)	Up to \$1,400 can be earned through Delta Health Rewards ¹	
Employee & Child(ren) (<i>Individual/Family</i>)	Up to \$700 can be earned through Delta Health Rewards ¹	
Family (<i>Individual/Family</i>)	Up to \$1,400 can be earned through Delta Health Rewards ¹	
¹ You may earn these amounts to be deposited in your 2019 HSA based on actions completed under the Delta Health Rewards program from January 1, 2019 to November 30, 2019. To see what you have earned, go to Rally SM on myuhc.com or contact Delta Health Direct at 877-912-1820.		
Annual Deductible		
Employee Only	\$3,100	\$6,200
Employee & Spouse (<i>Individual/Family</i>)	\$3,100/\$4,650	\$6,200/\$9,300
Employee & Child(ren) (<i>Individual/Family</i>)	\$3,100/\$4,650	\$6,200/\$9,300
Family (<i>Individual/Family</i>)	\$3,100/\$9,300	\$6,200/\$18,600
Coinsurance (<i>% paid by plan</i>)	Plan pays 80% after Deductible	Plan pays 60% of the Eligible Expense ² after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use and Prescription Drug Benefits; Amount is in Addition to the Deductible)		
Employee Only	\$3,300	\$6,600
Employee & Spouse (<i>Individual/Family</i>)	\$3,300/\$4,950	\$6,600/\$9,900
Employee & Child(ren) (<i>Individual/Family</i>)	\$3,300/\$4,950	\$6,600/\$9,900
Family (<i>Individual/Family</i>)	\$3,300/\$3,800	\$6,600/\$7,600
Out-of-Pocket Maximum		
HSA maximums include Deductible and Annual Coinsurance Maximum		
Employee Only	\$6,400	\$12,800
Employee & Spouse (<i>Individual/Family</i>)	\$6,400/\$9,600	\$12,800/\$19,200
Employee & Child(ren) (<i>Individual/Family</i>)	\$6,400/\$9,600	\$12,800/\$19,200
Family (<i>Individual/Family</i>)	\$6,400/\$13,100	\$12,800/\$26,200
Lifetime Max. Medical Benefit	No limit	

HEALTHCARE BENEFITS HANDBOOK

2019 Bronze HSA Medical Option		
	Network	Non-Network
Behavioral Healthcare³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Chiropractic Care <i>20 visits per calendar year</i>	80% covered after Deductible	Not covered
Durable Medical Equipment³ <i>Some rules about durable medical equipment apply</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Emergency Room Visits <i>Only covered if the visit is for a true medical Emergency</i>	80% covered after Deductible	80% covered after Deductible
Hospice Care³	100% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Hospital – Inpatient³ or Outpatient	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Lab Work – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Maternity³ <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	Up to the 4 th day: 100% After the 4 th day: 80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible Not covered if related to weight management or bariatric surgery
Office Visit – General	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Office Visit – Specialist	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Preventive Care <i>Preventive Lab Work and X-rays included</i>	100% covered; not subject to the Deductible	Not covered

HEALTHCARE BENEFITS HANDBOOK

2019 Bronze HSA Medical Option		
	Network	Non-Network
Substance Use³ <ul style="list-style-type: none"> • Inpatient Facility–Based Treatment • Outpatient Care Treatment 	80% covered after Deductible No day limits apply 80% covered after Deductible No day limits apply	60% of the Eligible Expense ² covered after Deductible No day limits apply 60% of the Eligible Expense ² covered after Deductible No day limits apply
Surgeon Services Assistant Surgeon Services Multiple Surgical Procedures <ul style="list-style-type: none"> • 1st procedure • 2nd procedure and subsequent procedures 	80% covered after Deductible 80% covered after Deductible 80% covered after Deductible 50% covered after Deductible	60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible 60% of the Eligible Expense ² covered after Deductible
Therapies <i>30 combined network and non-network treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ³ <ul style="list-style-type: none"> • Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services 	Covered with limitations	Not covered
X-Rays – Diagnostic	80% covered after Deductible	60% of the Eligible Expense ² covered after Deductible

² See "Eligible Expenses for Non-Network Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.

³ The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at 877-912-1820 or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

HEALTHCARE BENEFITS HANDBOOK

OOA GOLD HSA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 OOA Gold HSA Medical Option	
Delta-Provided Health Savings Account (HSA) Dollars	
Employee Only	Up to \$700 can be earned through Delta Health Rewards ¹
Employee & Spouse	Up to \$1,400 can be earned through Delta Health Rewards ¹
Employee & Child(ren)	\$250 automatic for children (plus up to \$1,100 can be earned through Delta Health Rewards) ¹
Family	\$250 automatic for children (plus up to \$1,800 can be earned through Delta Health Rewards) ¹
1. You may earn these amounts to be deposited in your 2019 HSA based on actions completed under the Delta Health Rewards program from January 1, 2019 to November 30, 2019. To see what you have earned, go to Rally SM on myuhc.com or contact Delta Health Direct at 877-912-1820.	
Annual Deductible	
Employee Only	\$1,350
Employee & Spouse <i>(Individual/Family)</i>	\$2,700
Employee & Child(ren) <i>(Individual/Family)</i>	\$2,700
Family <i>(Individual/Family)</i>	\$2,700
Coinsurance <i>(% paid by plan)</i>	Plan pays 80% of the Eligible Expense ² after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use and Prescription Drug Benefits; Amount is in Addition to the Deductible)	
Employee Only	\$2,500
Employee & Spouse <i>(Individual/Family)</i>	\$2,500/\$3,750
Employee & Child(ren) <i>(Individual/Family)</i>	\$2,500/\$3,750
Family <i>(Individual/Family)</i>	\$2,500/\$5,000
Out-of-Pocket Maximum	
HSA maximums include Deductible and Annual Coinsurance Maximum	
Employee Only	\$3,850
Employee & Spouse <i>(Individual/Family)</i>	\$3,850/\$6,450
Employee & Child(ren) <i>(Individual/Family)</i>	\$3,850/\$6,450
Family <i>(Individual/Family)</i>	\$3,850/\$7,700
Lifetime Maximum Medical Benefit	No limit

HEALTHCARE BENEFITS HANDBOOK

2019 OOA Gold HSA Medical Option

Behavioral Healthcare³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible No day limits apply</p> <p style="text-align: center;">80% of the Eligible Expense² covered after Deductible No day limits apply</p>
Chiropractic Care <i>20 visits per calendar year</i>	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Durable Medical Equipment³ <i>Some rules about durable medical equipment apply</i>	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Emergency Room Visits <i>Only covered if visit is for a true medical Emergency</i>	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Hospice Care³	<p style="text-align: center;">100% of the Eligible Expense² covered after Deductible</p>
Hospital – Inpatient³ or Outpatient	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Lab Work – Diagnostic	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Maternity³ <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	<p style="text-align: center;">Up to the 4th day: 100%</p> <p style="text-align: center;">After the 4th day: 80% of the Eligible Expense² covered after Deductible</p>
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Office Visit – General	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Office Visit – Specialist	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible</p>
Preventive Care <i>Preventive Lab Work and X-rays included</i>	<p style="text-align: center;">100% of the Eligible Expense² covered; not subject to the Deductible</p>
Substance Use³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	<p style="text-align: center;">80% of the Eligible Expense² covered after Deductible No day limits apply</p> <p style="text-align: center;">80% of the Eligible Expense² covered after Deductible No day limits apply</p>

HEALTHCARE BENEFITS HANDBOOK

2019 OOA Gold HSA Medical Option

Surgeon Services	80% of the Eligible Expense ² covered after Deductible
Assistant Surgeon Services	80% of the Eligible Expense ² covered after Deductible
Multiple Surgical Procedures <ul style="list-style-type: none"> • 1st procedure • 2nd procedure and subsequent procedures 	80% of the Eligible Expense ² covered after Deductible 50% of the Eligible Expense ² covered after Deductible
Therapies <i>30 treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	80% of the Eligible Expense ² covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ³ <ul style="list-style-type: none"> • Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services 	Covered with limitations
X-Rays – Diagnostic	80% of the Eligible Expense ¹ covered after Deductible

² See "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.

³ The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at 877-912-1820 or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

HEALTHCARE BENEFITS HANDBOOK

Retiree & Survivor Bronze HSA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 Retiree & Survivor Bronze HSA Medical Option		
	Network	Non-Network
Annual Deductible		
Employee Only	\$5,200	\$10,400
Employee & Spouse <i>(Individual/Family)</i>	\$5,200/\$7,800	\$10,400/\$15,600
Employee & Child(ren) <i>(Individual/Family)</i>	\$5,200/\$7,800	\$10,400/\$15,600
Family <i>(Individual/Family)</i>	\$5,200/\$13,100	\$10,400/\$26,200
Coinsurance <i>(% paid by plan)</i>	Plan pays 70% after Deductible	Plan pays 50% of the Eligible Expense ¹ after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use and Prescription Drug Benefits;) Amount is in Addition to the Deductible		
Employee Only	\$1,200	\$2,400
Employee & Spouse <i>(Individual/Family)</i>	\$1,200/\$1,800	\$2,400/\$3,600
Employee & Child(ren) <i>(Individual/Family)</i>	\$1,200/\$1,800	\$2,400/\$3,600
Family <i>(Individual/Family)</i>	\$1,200/\$0	\$2,400/\$0
Out-of-Pocket Maximum HSA maximums include Deductible and Annual Coinsurance Maximum		
Employee Only	\$6,400	\$12,800
Employee & Spouse <i>(Individual/Family)</i>	\$6,400/\$9,600	\$12,800/\$19,200
Employee & Child(ren) <i>(Individual/Family)</i>	\$6,400/\$9,600	\$12,800/\$19,200
Family <i>(Individual/Family)</i>	\$6,400/\$13,100	\$12,800/\$26,200
Lifetime Max. Medical Benefit	No limit	
Behavioral Healthcare²		
• Inpatient Facility-Based Treatment	70% covered after Deductible No day limits apply	50% of the Eligible Expense ¹ covered after Deductible No day limits apply
• Outpatient Care Treatment	70% covered after Deductible No day limits apply	50% of the Eligible Expense ¹ covered after Deductible No day limits apply
Chiropractic Care <i>20 visits per calendar year</i>	70% covered after Deductible	Not covered

HEALTHCARE BENEFITS HANDBOOK

2019 Retiree & Survivor Bronze HSA Medical Option		
	Network	Non-Network
Durable Medical Equipment² <i>Some rules about durable medical equipment apply</i>	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Emergency Room Visits <i>Only covered if the visit is for a true medical Emergency</i>	70% covered after Deductible	70% covered after Deductible
Hospice Care²	100% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Hospital – Inpatient² or Outpatient	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Lab Work – Diagnostic	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Maternity² <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	Up to the 4 th day: 100% After the 4 th day: 70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible Not covered if related to weight management or bariatric surgery
Office Visit – General	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Office Visit – Specialist	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Preventive Care <i>Preventive Lab Work and X-rays included</i>	100% covered; not subject to the Deductible	Not covered
Substance Use²		
• Inpatient Facility-Based Treatment	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
	No day limits apply	No day limits apply
• Outpatient Care Treatment	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
	No day limits apply	No day limits apply

HEALTHCARE BENEFITS HANDBOOK

2019 Retiree & Survivor Bronze HSA Medical Option

	Network	Non-Network
Surgeon Services	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Assistant Surgeon Services	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Multiple Surgical Procedures		
• 1st procedure	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
• 2nd procedure and subsequent procedures	50% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Therapies <i>30 combined network and non-network treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ²	Covered with limitations	Not covered
• Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services		
X-Rays – Diagnostic	70% covered after Deductible	50% of the Eligible Expense ¹ covered after Deductible

- 1 See "Eligible Expenses for Non-Network Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.
- 2 The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at 877-912-1820 or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

HEALTHCARE BENEFITS HANDBOOK

Retiree & Survivor Bronze OOA HSA Medical Option Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 Retiree & Survivor Bronze OOA HSA Medical Option	
Annual Deductible	
Employee Only	\$5,200
Employee & Spouse <i>(Individual/Family)</i>	\$5,200/\$7,800
Employee & Child(ren) <i>(Individual/Family)</i>	\$5,200/\$7,800
Family <i>(Individual/Family)</i>	\$5,200/\$13,100
Coinsurance <i>(% paid by plan)</i>	Plan pays 70% of the Eligible Expense ¹ after Deductible
Annual Coinsurance Maximum (Includes Behavioral Health/Substance Use and Prescription Drug Benefits; Amount is in Addition to the Deductible)	
Employee Only	\$1,200
Employee & Spouse <i>(Individual/Family)</i>	\$1,200/\$1,800
Employee & Child(ren) <i>(Individual/Family)</i>	\$1,200/\$1,800
Family <i>(Individual/Family)</i>	\$1,200/\$0
Out-of-Pocket Maximum HSA maximums include Deductible and Annual Coinsurance Maximum	
Employee Only	\$6,400
Employee & Spouse <i>(Individual/Family)</i>	\$6,400/\$9,600
Employee & Child(ren) <i>(Individual/Family)</i>	\$6,400/\$9,600
Family <i>(Individual/Family)</i>	\$6,400/\$13,100
Lifetime Maximum Medical Benefit	No limit
Behavioral Healthcare²	
• Inpatient Facility-Based Treatment	70% of the Eligible Expense ¹ covered after Deductible No day limits apply
• Outpatient Care Treatment	70% of the Eligible Expense ¹ covered after Deductible No day limits apply
Chiropractic Care <i>20 visits per calendar year</i>	70% of the Eligible Expense ¹ covered after Deductible
Durable Medical Equipment² <i>Some rules about durable medical equipment apply</i>	70% of the Eligible Expense ¹ covered after Deductible
Emergency Room Visits <i>Only covered if visit is for a true medical Emergency</i>	70% of the Eligible Expense ¹ covered after Deductible
Hospice Care²	100% of the Eligible Expense ¹ covered after Deductible
Hospital – Inpatient² or Outpatient	70% of the Eligible Expense ¹ covered after Deductible
Lab Work – Diagnostic	70% of the Eligible Expense ¹ covered after Deductible

HEALTHCARE BENEFITS HANDBOOK

2019 Retiree & Survivor Bronze OOA HSA Medical Option

Maternity² <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	70% of the Eligible Expense ¹ covered after Deductible
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	Up to the 4 th day: 100% After the 4 th day: 70% of the Eligible Expense ¹ covered after Deductible
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	70% of the Eligible Expense ¹ covered after Deductible
Office Visit – General	70% of the Eligible Expense ¹ covered after Deductible
Office Visit – Specialist	70% of the Eligible Expense ¹ covered after Deductible
Preventive Care <i>Preventive Lab Work and X-rays included</i>	100% of the Eligible Expense ¹ covered; not subject to the Deductible
Substance Use² <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	70% of the Eligible Expense ¹ covered after Deductible No day limits apply 70% of the Eligible Expense ¹ covered after Deductible No day limits apply
Surgeon Services	70% of the Eligible Expense ¹ covered after Deductible
Assistant Surgeon Services	70% of the Eligible Expense ¹ covered after Deductible
Multiple Surgical Procedures <ul style="list-style-type: none"> • 1st procedure • 2nd procedure and subsequent procedures 	70% of the Eligible Expense ¹ covered after Deductible 50% of the Eligible Expense ¹ covered after Deductible
Therapies <i>30 treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	70% of the Eligible Expense ¹ covered after Deductible
Weight Loss Bariatric surgery at Centers of Excellence ² <ul style="list-style-type: none"> • Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services 	Covered with limitations
X-Rays – Diagnostic	70% of the Eligible Expense ¹ covered after Deductible

1. See "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.
2. The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at 877-912-1820 or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

Prescription Drug Benefits — HSA Medical Options

When you enroll in an HSA Medical Option, you also receive prescription drug benefits.

Only prescriptions purchased at retail network pharmacies or through the mail order pharmacy administered by OptumRx™, a UnitedHealth Group Company, are covered under the HSA Medical Options. To find a network pharmacy, contact Delta Health Direct at **877-912-1820** or review the network pharmacy list at **myuhc.com**.

Your out-of-pocket expenses will vary based on the type of prescription you are filling:

- Preventive Drugs (e.g., some high blood pressure medications, some cholesterol medications, etc.) are available based on a tiered cost structure. You do not need to meet your Deductible before the plan pays part of the cost for these Preventive Drugs and, for that reason, they do not count toward your Deductible. However, your share of the cost for these Preventive Drugs counts toward your Annual Coinsurance Maximum
- For all other covered prescription drugs, you pay the full discounted cost until you reach the annual medical plan Deductible and you pay 20% of the full discounted cost up the Annual Coinsurance Maximum

Pharmacy prices vary, so it is a good idea to call at least three local network pharmacies for their costs before filling your prescription. Look into warehouse stores (some do not require you to buy a membership when you are only filling a prescription), as well as “big box” retailers (some of whom offer \$4 generics). Also, a growing number of supermarkets offer a free 14-day supply of several antibiotics. Look in these same places for good prices on over-the-counter remedies.

Please Note Tier 4 drugs (see later in this “Prescription Drug Benefits – HSA Medical Options” section for information on Drug Tiers) are not covered by the HSA Medical Options. While you can receive a discounted price on these drugs if purchased at a network pharmacy, you will have to pay 100% of this discounted cost and, because they are not covered by the Plan, these expenses do not count toward any out-of-pocket expenses (i.e., your Deductible or Annual Coinsurance Maximum).

Preventive Drugs

Preventive Drugs are those prescribed to prevent the occurrence of a disease or condition for those individuals with risk factors, or to prevent the recurrence of a disease or condition for those who have recovered. Preventive medications may be those used for the prevention of conditions, such as high blood pressure, high cholesterol, osteoporosis, heart attack, and prenatal nutrient deficiency.

Medications may be removed from the Preventive Drug list or move to a higher tier up to two times per calendar year. When a medication changes tiers, you may be required to pay more or less for that medication. For the most current information on your pharmacy coverage, call Delta Health Direct at **877-912-1820** or visit **myuhc.com**.

You can view the Preventive Drug list on Benefits Direct, which is accessible through Deltanet. You can also access the Preventive Drug list at **myuhc.com**.

Statins for Primary Prevention of Cardiovascular Disease

The United States Preventive Services Task Force (USPSTF) now recommends low-to moderate-dose intensity statins be provided for primary prevention of cardiovascular disease (CVD) in individuals at high risk. Certain statins will be covered at 100% (prior authorization may be required) for members who meet specific coverage criteria:

- Being age 40-75,
- Having one or more cardiovascular risk factors such as dyslipidemia, diabetes, hypertension or smoking, and
- Having a calculated 10-year risk of a cardiovascular event of 10% or greater. This will require universal lipid screening for this age group.

Statins to Be Covered at \$0 Cost Share

No Prior Authorization required (Ages 40-75)	lovastatin (generic Mevacor); all strengths
Prior Authorization required to confirm risk of cardiovascular disease	atorvastatin (generic Lipitor); 10 & 20 mg* simvastatin (generic Zocor); 5, 10, 20 & 40 mg*

* Only these strengths are available for \$0 cost share

Call Delta Health Direct at **877-912-1820** for more information.

Prescription Drug List

A Prescription Drug List (PDL) is a list of Food and Drug Administration (FDA) approved brand name and generic medications. The UHC pharmacy benefit provides coverage for a comprehensive list of prescription medications.

The UHC PDL Management Committee makes tier placement decisions to help ensure access to a wide range of medications. The Committee is composed of senior level physicians and business leaders who decide the tier placement of a particular prescription medication based on clinical information from the UHC Pharmacy and Therapeutics (P&T) Committee, as well as economic and financial considerations. The Committee looks at the overall healthcare value of a particular medication to balance the need for flexibility and choice for participants with an affordable pharmacy benefit.

Medications may be removed from the PDL or move to a higher tier up to two times per calendar year. Additionally, when a brand name medication becomes available as a generic, the tier status of the brand name medication and its corresponding generic are evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. Drugs not on the PDL are not covered expenses under the Plan. For the most current information on your pharmacy coverage, call Delta Health Direct at **877-912-1820** or visit **myuhc.com**.

You can view UHC's PDL on Benefits Direct on Deltanet. You can also access the drug list at **myuhc.com**.

Generic Substitution Program or “Member-Pays-the-Difference”

The pharmacy benefit includes a generic substitution program (referred to as “member-pays-the-difference”) that requires medications to be dispensed as generic drugs rather than brand name drugs if a chemically equivalent generic drug exists. The generic substitution will be dispensed by your pharmacist according to state law and your physician’s approval.

For Preventive Drugs, the Plan requires that if you or your physician choose to receive a brand name drug when a generic is available, you will be required to pay the brand Copay/Coinsurance plus 100% of the difference in the cost of the two drugs. The “member-pays-the-difference” amount (or ancillary charge) counts toward your annual Out-of-Pocket Maximum. Once your annual Out-of-Pocket Maximum has been met, the Plan will pay 100% of the cost of the brand name preventive drug for the rest of the benefit plan year.

If the drug is not a Preventive Drug and you or your physician choose to fill the brand name drug over the chemically equivalent generic substitution, you will be responsible for the full discounted cost of the drug until you meet your combined medical and prescription drug annual Deductible. After the Deductible is met, your prescription drug coverage will move to a tiered structure for all of your covered drugs and you are then required to pay the brand Copay/Coinsurance plus 100% of the difference in the cost of the two drugs. The “member-pays-the-difference” amount (or ancillary charge) counts towards your Deductible and annual Out-of-Pocket Maximum. Once your annual Out-of-Pocket Maximum has been met, the Plan will pay 100% of the cost of the brand name drug for the rest of the benefit plan year.

Prior Authorization

Before certain prescription Drugs are dispensed to you, they must receive prior authorization approval from UnitedHealthcare. Prior authorization is a formal process that your doctor goes through. He or she must give a medical reason why they are prescribing that medicine and UnitedHealthcare determines if the prescription drug is:

- A Covered Service
- Medically Necessary
- Not experimental, investigational or unproven

This process helps the Plan keep costs down for everyone by having doctors prescribe appropriate medications based on members’ individual medical conditions.

If prior authorization is required for your prescription drug and is not approved, you will have to pay 100% of the price, and these expenses do not count towards your Deductible or Annual Coinsurance Maximum since it is not covered by the Plan.

To determine if a prescription drug requires prior authorization, check UHC’s Prescription Drug List (PDL) on Deltanet. You can also access the PDL at myuhc.com or call Delta Health Direct at **877-912-1820**.

Specialty Pharmacy Program

Specialty medications to treat certain chronic illness are only covered by the Specialty Pharmacy Program rather than the retail or mail order programs. The mandatory Specialty Pharmacy Program is designed to better manage the cost and quality of services available to users of these high-cost medications. If you use a specialty medication, UHC will notify you directly with details regarding this program. If you choose to obtain the specialty medication at a retail or mail order pharmacy other than the named Specialty Pharmacy, the medication is not covered by the Plan and you will pay the full cost. It also will not count toward your Deductible or Annual Coinsurance Maximum since it is not covered by the Plan.

Select Designated Pharmacy Program

The Select Designated Pharmacy Program administered by OptumRx™ applies to a select number of high-cost, brand-name drugs that are covered by the plan. This program offers the impacted participants with cost-saving options, including receiving the drug you were prescribed by mail order delivery or receiving a lower-cost alternative drug at your retail pharmacy or by mail order delivery. The program also helps members understand their medications and savings options through the use of letters, point-of-sale messaging at the retail pharmacy, and outgoing calls. If you use a medication that is part of the Select Designated Pharmacy Program, UHC will notify you directly with details regarding this program.

Refill and Save Program - Preventive Drugs Only

People who take their medication as prescribed are less likely to need additional medication down the road. Members who fill their prescription for a qualifying Refill and Save Program Preventive Drug as prescribed are given a \$20 savings off their usual Copay or Coinsurance. For those refilling by mail order, they will receive an average reduction of \$50 on their Copay or Coinsurance based on a 90-day supply. This program is automatic for those taking a qualifying Preventive Drug prescription.

Members who refill these qualifying medications on a regular basis will receive a lower Copay or Coinsurance at the pharmacy; members do not have to sign up to receive the benefits. To qualify, members must refill their prescription within 30 days of the day it was scheduled to run out. For example, if the prescription were written for 30 days, the member would have that 30 days plus a 30-day grace period (for a total of 60 days) to refill the prescription in order to qualify.

Call Delta Health Direct at **877-912-1820** for more information.

Drug Tiers

Prescription drugs costs are based on their tier. There are four tiers. Generally, Tier 1 is made up of generics and other low-cost drugs. Tiers 2-4 are typically made up of higher cost and brand-name drugs. Tier 4 medications are not covered by the Plan.

Preventive Prescription Drugs

Tier 1 Preventive Drugs are available for a flat \$10 Copay for retail or \$25 for mail order — or lower, if the actual cost is less than \$10/\$25.

When you purchase a Tier 2 or Tier 3 Preventive Drug, you pay Coinsurance — up to 20% of the cost of the drug. The plan covers the remainder. However, set minimum and maximum amount limits are in place for each of these three tiers.

These minimum and maximum amounts vary depending on which tier the Preventive Drug falls under.

- When 20% of the cost of the Preventive Drug is LESS than the minimum limit, you pay the minimum limit (\$30 Tier 2 or \$50 Tier 3 for retail; \$75 Tier 2 or \$125 Tier 3 for mail order)
- When 20% of the cost of the Preventive Drug is MORE than the minimum limit, but LESS than the maximum limit, you pay the 20% Coinsurance
- When 20% of the cost of the Preventive Drug is MORE than the maximum limit, you pay the maximum limit (\$75 Tier 2 or \$125 Tier 3 for retail; \$175 Tier 2 or \$300 Tier 3 for mail order)
- When the total cost of the Preventive Drug is LESS than the minimum limit, you pay the total cost of the prescription

Your Copays or Coinsurance for a Preventive Drug do not count toward your Deductible, but they do count toward your Coinsurance Maximum.

Since a Tier 4 drug is not covered by the Plan, you pay 100% of the cost of the drug, though you may receive a discounted price due to your HSA Medical Plan coverage. The costs you pay for drugs in Tier 4 do not apply to the Deductible and Annual Coinsurance Maximum since they are not covered by the Plan.

Visit the “Price a Medication” tool on myuhc.com to find out on which tier your drug is classified. Note that prescription drug tier information is updated quarterly by UHC.

All Other Drugs

For all other covered drugs (medications that are on the Prescription Drug List but not on the Preventive Drug list), you pay the full cost of the prescription up to the annual Deductible.

Once you meet your annual Deductible, the same tier structure that applies to Preventive Drugs will apply to all other drugs covered by the Plan.

Tier 1 drugs are available for a flat \$10 Copay for retail or \$25 for mail order — or lower, if the actual cost is less than \$10/\$25.

When you purchase a Tier 2 or Tier 3 drug, you pay Coinsurance — up to 20% of the cost of the drug. The plan covers the remainder. However, set minimum and maximum amount limits are in place for each of these three tiers.

These minimum and maximum amounts vary depending on which tier the Preventive Drug falls under.

- When 20% of the cost of the drug is LESS than the minimum limit, you pay the minimum limit (\$30 Tier 2 or \$50 Tier 3 for retail; \$75 Tier 2 or \$125 Tier 3 for mail order)
- When 20% of the cost of the drug is MORE than the minimum limit, but LESS than the maximum limit, you pay the 20% Coinsurance
- When 20% of the cost of the drug is MORE than the maximum limit, you pay the maximum limit (\$75 Tier 2 or \$125 Tier 3 for retail; \$175 Tier 2 or \$300 Tier 3 for mail order)
- When the total cost of the drug is LESS than the minimum limit, you pay the total cost of the prescription

Your Copays or Coinsurance count toward your Coinsurance Maximum.

Since Tier 4 drugs are not covered by the Plan, you pay 100% of the cost of the drug, though you may receive a discounted price due to your HSA Medical Plan coverage. The cost you pay for drugs in Tier 4 do not apply to the annual Deductible and Annual Coinsurance Maximum since they are not covered by the Plan.

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Prescription Drug Benefit Overview — HSA Medical Options

2019 Prescription Drug Benefits — HSA Medical Options*		
Only prescriptions purchased at network pharmacies or the mail order pharmacy are covered		
	Retail	Mail Order
Preventive Drugs		
Tier 1	\$10 Copay	\$25 Copay
Tier 2	20% (\$30 min/\$75 max)	20% (\$75 min/\$175 max)
Tier 3	20% (\$50 min/\$125 max)	20% (\$125 min/\$300 max)
Tier 4**	Not covered	Not covered
All Other Medications – Prior to Meeting Annual Deductible		
	Full cost of prescription up to the Deductible Tier 4 not covered**	Full cost of prescription up to the Deductible Tier 4 not covered**
All Other Medications – After Meeting Annual Deductible		
Tier 1	\$10 Copay	\$25 Copay
Tier 2	20% (\$30 min/\$75 max)	20% (\$75 min/\$175 max)
Tier 3	20% (\$50 min/\$125 max)	20% (\$125 min/\$300 max)
Tier 4**	Not covered	Not covered

* Mandatory generics apply. This program requires that prescriptions be filled with the generic product, if one is available. If you purchase a brand name drug when a chemically equivalent generic is available, you are required to pay the brand Copay/Coinsurance plus 100% of the difference in the cost of the two drugs – the ancillary charge. See the “Generic Substitution Program or Member-Pays-the-Difference” earlier in this section for details on how your Deductible and Out-of-Pocket Maximum may be impacted by this ancillary charge. As of December 1, 2017, select statins are covered at \$0 cost-share for members who meet specific coverage criteria under new Affordable Care Act regulations. See “Statins for Primary Prevention of Cardiovascular Disease” earlier in this section for details.

** Since Tier 4 drugs are not covered by the Plan, you pay 100% of the cost of the drug, though you may receive a discounted price due to your HSA Medical Plan coverage. The cost you pay for drugs in Tier 4 do not apply to the annual Deductible and Annual Coinsurance Maximum since they are not covered by the Plan.

Note: The 2019 Preventive Drug list and the 2019 Prescription Drug List (PDL) can be found on Benefits Direct on Deltanet. You can also access the drug list at myuhc.com.

For Pharmacy Program Details

To find a network pharmacy, get prescription drug information or request a mail order claim form, you may contact Delta Health Direct at **877-912-1820**. You also can view the network pharmacy list, Preventive Drug list and the PDL at myuhc.com.

How the Puerto Rico Out-of-Area Plan Works

The Puerto Rico Out-of-Area (OOA) Medical Option is only available to residents of Puerto Rico who live outside of the UHC service area.

Annual Deductible

The annual Deductible is the dollar amount of covered expenses that you must pay before the plan begins to pay benefits each calendar year. With the Puerto Rico OOA Medical Option, you have one Deductible to meet, regardless of whether you receive services through the UHC network.

Prescription drug costs are not applied to the medical Deductibles for the Puerto Rico OOA Medical Option, nor are amounts above the plan's maximum reimbursement rate (described later in this section).

2019 Puerto Rico OOA Medical Option Annual Deductibles	
Employee Only	\$400
Employee & Spouse	\$1,200
Employee & Child(ren)	
Family	

How Family Members Meet the Deductible

Once an enrolled family member meets his or her individual Deductible, the plan begins to pay his or her eligible expenses at the applicable Coinsurance amount (see chart below). Then, Deductible-eligible expenses paid by any combination of the other family members will accumulate to meet the combined family Deductible. If the family Deductible is met before an individual family member reaches his or her own individual Deductible, plan benefits and Coinsurance apply for all family members.

Coinsurance

Once you and/or your dependents have met your annual Deductible, you share expenses with the plan. Your portion of these expenses is called your Coinsurance. The Puerto Rico OOA Medical Option generally pays 80% of the Eligible Expense for Covered Services, while you pay the remaining 20%.

2019 Puerto Rico OOA Medical Option Coinsurance	
You Pay	20%*
Plan Pays	80%*

* Based on Eligible Expenses (see "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined). In addition to the Coinsurance, you are responsible for 100% of the difference between billed charges and the Eligible Expense. The plans do not cover this difference, and these amounts do not apply to the Deductible or Out-of-Pocket Maximum.

Annual Out-of-Pocket Maximum

With the Puerto Rico OOA Medical Option, the most you would be required to spend out of pocket on Coinsurance in any year for medical expenses is known as the annual Out-of-Pocket Maximum. Once your Coinsurance payments reach this dollar limit, the plan pays 100% for Covered Services for the remainder of the plan (calendar) year.

The Deductible does not count toward the Out-of-Pocket Maximum, and any amounts in excess of the Eligible Expense are not covered by the plan and therefore are not applied to the Out-of-Pocket

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Maximum. You, not the Plan, must always pay 100% of these excess amounts. Also, prescription drug copays do not count toward the medical Out-of-Pocket Maximum.

2019 Puerto Rico OOA Medical Option Annual Out-of-Pocket Maximums	
Employee Only	\$3,000
Employee & Spouse	\$6,000
Employee & Child(ren)	
Family	

How Family Members Meet the Annual Out-of-Pocket Maximum

For employee & spouse, employee & child(ren) and family levels of coverage, a family member is only required to meet his or her individual Out-of-Pocket Maximum before the plan begins paying 100% for that one family member.

Example: An individual who has family coverage under the Puerto Rico OOA Medical Option would reach the annual Out-of-Pocket Maximum once his or her covered medical expenses add up to \$3,000 (excluding Deductibles) for the year. This individual's covered medical expenses would then be paid by the plan at 100% for the rest of the year. The individual would not have to wait until the entire family's covered expenses reach \$6,000 for this to happen.

Behavioral Health and Substance Use Benefits

Your mental health is just as important as your physical health. Therefore, when you enroll in the Puerto Rico OOA Medical Option, you automatically receive behavioral health benefits and substance use treatment benefits (BH/SU) through OptumHealth Behavioral Solutions. You may seek behavioral health services either through a Network or Non-Network Provider.

Costs for behavioral health services apply toward your medical Deductible and annual Out-of-Pocket Maximum.

Prior Authorization from OptumHealth Behavioral Solutions is required for certain BH/SU services. Be sure to read the "When You Must Notify UHC or OptumHealth Behavioral Solutions" section earlier in this "Medical Benefits" section for details.

For full coverage details about BH/SU services, refer to the section, "What the Delta Medical Plans Cover," which appears later in this "Medical Benefits" section of this handbook.

Prescription Drug Benefits

Prescription drug benefits for both retail and mail order prescriptions are included with the Puerto Rico OOA Medical Plan Option. UnitedHealthcare administers the program, with the mail order pharmacy administered by OptumRx™, a UnitedHealth Group Company.

Your prescription drug expenses do not count toward your annual medical Deductible.

You generally save money on prescription drugs if you purchase available generics (if they are right for you) and medications on UnitedHealthcare's Prescription Drug List (PDL). You can view the PDL on Benefits Direct on Deltanet. You can also access the drug list at myuhc.com.

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Puerto Rico OOA Overview

Services and supplies eligible for coverage must be provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom, and meet certain established criteria. For more details about eligible Covered Services, see "What the Delta Medical Plans Cover" later in this "Medical Benefits" section.

2019 Puerto Rico OOA Medical Option	
Annual Deductible¹	
Employee Only	\$400
Employee & Spouse	\$1,200
Employee & Child(ren)	
Family	
Coinsurance (<i>% paid by plan</i>)	80% of the Eligible Expense ² after Deductible
1 Does not include prescription drug Copays.	
Annual Out-of-Pocket Maximum (Includes Behavioral Health/Substance Use Benefits; Excludes Deductible)	
Employee Only	\$3,000
Employee & Spouse	\$6,000
Employee & Child(ren)	
Family	
Lifetime Maximum Medical Benefit	No limit
Behavioral Healthcare³	
• Inpatient Facility-Based Treatment	80% of the Eligible Expense ² after Deductible No day limits
• Outpatient Care Treatment	80% of the Eligible Expense ² after Deductible No day limits
Chiropractic Care <i>Limit of 20 visits per calendar year</i>	80% of the Eligible Expense ² after Deductible
Durable Medical Equipment³	80% of the Eligible Expense ² after Deductible
Emergency Room Visit	80% of the Eligible Expense ² after Deductible
Hospice Care³	80% of the Eligible Expense ² after Deductible
Hospital – Inpatient³ or Outpatient	80% of the Eligible Expense ² after Deductible
Lab Work – Diagnostic	80% of the Eligible Expense ² after Deductible
Maternity³ <i>Physician and facility services included (including eligible healthcare expenses incurred to treat and care for an enrolled dependent child's pregnancy)</i>	80% of the Eligible Expense ² after Deductible

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2019 Puerto Rico OOA Medical Option	
Newborn Care <i>This Newborn Care benefit is limited to 31 days following birth (or 4 days following birth for a grandchild when the mother is a covered dependent child). You must enroll newborns as a covered dependent within 60 days of birth for coverage past this time.</i>	Up to the 4 th day: 100% After the 4 th day: 80% of the Eligible Expense ² covered after Deductible
Nutritional Counseling <i>Six visits per calendar year. Note: If you have a medical condition, three additional visits are covered, subject to clinical review.</i>	80% of the Eligible Expense ² after Deductible
Office Visit – General	80% of the Eligible Expense ² after Deductible
Office Visit – Specialist	80% of the Eligible Expense ² after Deductible
Preventive Care <i>Preventive Lab Work and X-rays included</i>	100% of the Eligible Expense ² ; not subject to the Deductible
Substance Use³ <ul style="list-style-type: none"> • Inpatient Facility-Based Treatment • Outpatient Care Treatment 	80% of the Eligible Expense ² after Deductible No day limits 80% of the Eligible Expense ² after Deductible No day limits
Surgeon Services Assistant Surgeon Services Multiple Surgical Procedures <ul style="list-style-type: none"> • 1st procedure • 2nd procedure and subsequent procedures 	80% of the Eligible Expense ² after Deductible 80% of the Eligible Expense ² after Deductible 80% of the Eligible Expense ² after Deductible 50% of the Eligible Expense ² after Deductible
Therapies <i>30 treatments per type of therapy per calendar year; medical review necessary beyond 30 treatments</i>	80% of the Eligible Expense ² after Deductible
Weight Loss Bariatric surgery at Centers of Excellence Only ³ <ul style="list-style-type: none"> • Covered with limitations only with Prior Authorization from UHC, when using a Center of Excellence and receiving network services 	Covered with limitations
X-Rays – Diagnostic	80% of the Eligible Expense ² after Deductible

2 See "Eligible Expenses for Out-of-Area Benefits" earlier in this "Medical Benefits" section for details on how the Eligible Expense is determined.

3 The covered participant or his or her doctor/provider must notify UHC (or OptumHealth Behavioral Solutions for behavioral healthcare or substance use benefits) to obtain Prior Authorization before these services are rendered or procedures are performed. If Prior Authorization is not obtained from UHC by calling Delta Health Direct at 877-912-1820 or if some/all of the services are not authorized, the procedure is not covered by the Plan and you will be responsible for paying all charges. Be sure to check "Medical Plan Features" earlier in this section and "What The Delta Medical Plans Cover" later in this section for details regarding Prior Authorization requirements of a particular benefit.

Prescription Drug Benefits — Puerto Rico OOA Medical Option

When you enroll in the Puerto Rico OOA Medical Option, you also receive prescription drug benefits.

Only prescriptions purchased at network pharmacies or through the mail order pharmacy administered by OptumRx™, a UnitedHealth Group Company are covered under the Puerto Rico OOA Medical Option.

Additionally, prescription drug expenses are handled separately from medical expenses. This means that prescription drug expenses do not count toward your annual medical Deductible or medical annual Out-of-Pocket Maximum.

Please Note: Tier 4 drugs (see following page for information on Drug Tiers) are not covered by the Puerto Rico OOA Medical Option. While you can receive a discounted price on these drugs if purchased at a network pharmacy, you will have to pay 100% of this discounted cost.

Statins for Primary Prevention of Cardiovascular Disease

The United States Preventive Services Task Force (USPSTF) now recommends low-to moderate-dose intensity statins be provided for primary prevention of cardiovascular disease (CVD) in individuals at high risk. Certain statins will be covered at 100% (prior authorization may be required) for members who meet specific coverage criteria:

- Being age 40-75,
- Having one or more cardiovascular risk factors such as dyslipidemia, diabetes, hypertension or smoking, and
- Having a calculated 10-year risk of a cardiovascular event of 10% or greater. This will require universal lipid screening for this age group.

Statins to Be Covered at \$0 Cost Share

No Prior Authorization required (Ages 40-75)	lovastatin (generic Mevacor); all strengths
Prior Authorization required to confirm risk of cardiovascular disease	atorvastatin (generic Lipitor); 10 & 20 mg* simvastatin (generic Zocor); 5, 10, 20 & 40 mg*

* Only these strengths are available for \$0 cost share

Call Delta Health Direct at **877-912-1820** for more information.

Prescription Drug List

A Prescription Drug List (PDL) is a list of Food and Drug Administration (FDA) approved brand name and generic medications. The UHC pharmacy benefit provides coverage for a comprehensive list of prescription medications.

The UHC PDL Management Committee makes tier placement decisions to help ensure access to a wide range of medications. The Committee is composed of senior level physicians and business leaders who decide the tier placement of a particular prescription medication based on clinical information from the UHC Pharmacy and Therapeutics (P&T) Committee, as well as economic and financial considerations. The Committee looks at the overall healthcare value of a particular medication to balance the need for flexibility and choice for participants with an affordable pharmacy benefit.

Medications may be removed from the PDL or move to a higher tier up to two times per calendar year. Additionally, when a brand name medication becomes available as a generic, the tier status of the brand name medication and its corresponding generic are evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. Drugs not on the PDL are not considered to be covered expenses. For the most current information on your pharmacy coverage, call Delta Health Direct at **877-912-1820** or visit **myuhc.com**.

You can view UHC's PDL on Benefits Direct on Deltanet. You can also access the drug list at **myuhc.com**.

Prior Authorization

Before certain prescription Drugs are dispensed to you, they must receive prior authorization approval from UnitedHealthcare. Prior authorization is a formal process that your doctor goes through. He or she must give a medical reason why they are prescribing that medicine and UnitedHealthcare determines if the prescription drug is:

- A Covered Service
- Medically Necessary
- Not Experimental, Investigational or Unproven

This process helps the Plan keep costs down for everyone by having doctors prescribe appropriate medications based on members' individual medical conditions.

If prior authorization is required for your prescription drug and is not approved, you will have to pay 100% of the price, and these expenses do not count towards your Deductible or Annual Out-of-Pocket Maximum since it is not covered by the Plan.

To determine if a prescription drug requires prior authorization, check UHC's Prescription Drug List (PDL). You can view UHC's PDL on Benefits Direct on Deltanet. You can also access the drug list at **myuhc.com** or call Delta Health Direct at **877-912-1820**.

Specialty Pharmacy Program

Specialty medications to treat certain chronic illness are only covered by the Specialty Pharmacy Program rather than the retail or mail order programs. The mandatory Specialty Pharmacy Program is designed to better manage the cost and quality of services available to users of these high-cost medications. If you use a specialty medication, UHC will notify you directly with details regarding this program. If you choose to obtain the specialty medication at a retail or mail order pharmacy other than the named Specialty Pharmacy, the medication is not covered by the Plan and you will pay the full cost. It also will not count toward your Deductible or Annual Out-of-Pocket Maximum since it is not covered by the Plan.

Refill and Save Program

People who take their medication as prescribed are less likely to need additional medication down the road. Members who fill their prescription for a qualifying Refill and Save Program medication as prescribed are given a \$20 savings off their usual Copay. For those refilling by mail order, they will receive an average reduction of \$50 on their Copay based on a 90-day supply. This program is automatic for those taking a qualifying prescription.

Members who refill these qualifying medications on a regular basis will receive a lower Copay at the pharmacy; members do not have to sign up to receive the benefits. To qualify, members must refill

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their prescription within 30 days of the day it was scheduled to run out. For example, if the prescription were written for 30 days, the member would have that 30 days plus a 30-day grace period (for a total of 60 days) to refill the prescription in order to qualify.

Call Delta Health Direct at **877-912-1820** for more information.

Drug Tiers

Prescription drugs costs are based on their tier. There are four tiers. Generally, Tier 1 is made up of generics and other low-cost drugs. Tiers 2-4 are typically made up of higher cost and brand-name drugs. Tier 4 medications are not covered by the Plan, though you may receive a discounted price due to your Puerto Rico OOA Medical Option coverage.

Visit the "Price a Medication" tool on myuhc.com to find out on which tier your drug is classified. Note that prescription drug tier information is updated quarterly by UHC.

Prescription Drug Benefit Overview — Puerto Rico OOA Medical Option

2019 Prescription Drug Benefits — Puerto Rico OOA Medical Option*	
Retail Pharmacy (up to 31-day supply) Member Pays	
Tier 1	\$10 Copay
Tier 2	\$30 Copay
Tier 3	\$60 Copay
Tier 4**	Not covered
Mail Order Pharmacy (90-day supply) Member Pays	
Tier 1	\$25 Copay
Tier 2	\$75 Copay
Tier 3	\$150 Copay
Tier 4**	Not covered

* As of December 1, 2017, select statins are covered at \$0 cost-share for members who meet specific coverage criteria under new Affordable Care Act regulations. See "Statins for Primary Prevention of Cardiovascular Disease" earlier in this section for details.

** Since Tier 4 drugs are not covered by the Plan, you pay 100% of the cost of the drug, though you may receive a discounted price due to your Puerto Rico OOA Medical Option coverage.

For Pharmacy Program Details

To find a network pharmacy, get prescription drug information or request a mail order claim form, you may contact Delta Health Direct at **877-912-1820**. You also can view the network pharmacy list and the PDL at **myuhc.com**.

WHAT THE DELTA MEDICAL PLANS COVER

This section describes coverage under all the Delta Account-Based Healthcare Plan (DABHP) Medical Options.

In general, all medical plans offered by Delta cover hospital, surgical, physician and X-ray/laboratory services, prescription drugs, and other medical services and supplies for the treatment of non-occupational illnesses, diseases, injuries and Preventive Care.

The amount that the medical options pay, as well as the Coinsurance amounts required of you, varies depending on the specific medical option in which you are enrolled. Some of the medical options offered by Delta feature lower coverage levels for services received from Non-Network Providers. Also, limits may apply to some of the Covered Services.

For specific details regarding network and non-network Coinsurance coverage levels, refer to each medical plan's "Overview" chart, appearing earlier in this "Medical Benefits" section. Also review the descriptions of covered benefits outlined here.

You or your Network Provider must contact Delta Health Direct at **877-912-1820** before receiving certain Covered Services. For more information about this, see "When You Must Obtain Prior Authorization UHC or OptumHealth Behavioral Solutions," which appears toward the beginning of this "Medical Benefits" section of the handbook.

The services and supplies described on the following pages are Covered Services under the plan only if they are health services, supplies, equipment or pharmaceutical products provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom and meet the other criteria described in this "Medical Benefits" section. They must be provided:

- When the plan is in effect;
- Before the date of the individual termination conditions set forth in the plan; and
- Only when the recipient is a covered person who meets all eligibility requirements specified in the plan

These supplies and services also must meet each of the following criteria:

- They are consistent with conclusions of prevailing medical research that demonstrate that the health services have a beneficial effect on health outcomes
- They are the most cost-effective method that yields a similar outcome to other available alternatives
- They are health services, supplies or amounts that are not specifically excluded in any section of this handbook, including the "What the Delta Medical Plans Do Not Cover" in later in this "Medical Benefits" section of the handbook.

New technologies, procedures and treatments must meet all criteria described above to be considered for coverage.

Abortion

Therapeutic abortions are covered. Voluntary or elective abortions are not covered.

Acupuncture

Acupuncture is a Covered Service for the treatment of nausea due to chemotherapy, nausea in early pregnancy or post-operative nausea, and in lieu of conventional anesthesia. Acupuncture must be provided by a provider who is licensed by the state or certified by the National Commission of Acupuncturists.

Treatment is limited to a total of 15 combined network and non-network visits per calendar year.

Allergy Testing and Injections

The plans cover allergy treatment including testing, sera and injections by a physician, allergist or specialist.

Ambulance*Emergency Ambulance Services*

- Emergency ambulance services are covered at an in-network benefit level when provided by a licensed ambulance service (either in network or out of network) from the place of injury or sickness to the nearest hospital that offers Emergency treatment
- Emergency air ambulance services are covered at an in-network benefit level if the requirements in the previous paragraph are met and ground ambulance transportation is impossible, or would put the patient's life or health in serious jeopardy
- Coverage for Emergency air ambulance services to a hospital that is not the closest facility may be approved at an in-network benefit level if special circumstances exist (as determined by the claims administrator)

Non-Emergency Ambulance Services

Non-Emergency ambulance transportation provided by a licensed ambulance service (either ground ambulance or air ambulance, as determined appropriate by the claims administrator) is only covered for transfers between facilities when the transport is:

- From a non-network hospital to the closest most clinically appropriate* network hospital
- To the closest most clinically appropriate* hospital that provides a higher level of care that was not available at the hospital transferred from
- As determined by the claims administrator from a non-network to network acute care facility, in cases where a longer length patient stay is required
- From an acute care facility to the closest most clinically appropriate* sub-acute setting

Note: Ambulance services and transportation for the convenience of the patient or the patient's family (i.e., transportation from a facility not close to the patient's home to one which is closer to the patient's home) is not covered by the plan and the participant is responsible in full for the charges.

You or your physician/healthcare provider must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** as soon as possible prior to a non-Emergency transport by air ambulance. If you do not receive this Prior Authorization or if the service is not authorized you will be responsible for paying all charges and no benefits will be paid by the Plan.

* Whether a hospital or facility is most clinically appropriate is determined by the claims administrator.

Ambulatory Surgical Center

An ambulatory surgical center is a specialized facility that is established, equipped, operated and staffed primarily to perform surgical procedures. The center must either be licensed or meet the UHC guidelines for a non-licensed facility. Surgical procedures performed in an ambulatory surgical center by properly licensed healthcare professionals are considered Covered Services.

Anesthesia

See "Hospital Care" described later in this list of Covered Services.

Audiologists – Non-Preventive Care

Coverage is subject to the underlying condition.

Bariatric Surgery

The surgical treatment of morbid obesity is a Covered Service, provided all of the following are true:

- You have a minimum Body Mass Index (BMI) of 40, or 35 with at least two co-morbid conditions present,
- You are over the age of 21,
- You must use an OptumHealth/URN Bariatric Center of Excellence,
- You have completed a six-month physician-supervised weight loss program
- You have completed a pre-surgical psychological evaluation
- You have been employed by Delta and/or Northwest Airlines, Delta Vacations, DMS or DFP for a minimum of one (1) year prior to the surgery

These requirements apply for you or an enrolled covered dependent to be eligible for bariatric (obesity/weight loss) surgery, to include gastric stapling and diversion.

In order for the plan to consider bariatric surgery a Covered Service, you must contact Delta Health Direct at **877-912-1820** and speak with a nurse consultant to obtain Prior Authorization before you receive any services. Upon contacting Delta Health Direct and receiving authorization, you will have access to a network of facilities and physicians who participate in the Bariatric Resource Service (BRS) program. These BRS facilities and physicians are known as Bariatric Centers of Excellence. They can provide specialized clinical consulting services for you and/or your enrolled covered dependents as well as education on obesity treatment options.

Surgical services, inpatient stay and facility charges associated with bariatric surgery (which has been properly initiated and authorized through the BRS Program) will be considered Covered Services.

Your bariatric surgery must be performed at a Center of Excellence. You should use Bariatric Resource Services for help in determining your best treatment options as well as to assist in the coordination of your surgery.

Covered participants seeking Prior Authorization for bariatric surgery should notify Delta Health Direct as soon as the possibility of a bariatric surgery procedure arises and before the time a pre-surgical evaluation is performed. To obtain further information and Prior Authorization, contact Delta Health Direct at **877-912-1820**. Any bariatric surgery that is not authorized and performed through the BRS program will not be covered by the Plan and you will be responsible for paying all charges.

Behavioral Health, Substance Use Disorder Treatment and Neurobiological Disorders - Autism Spectrum Disorder Services

Behavioral health/substance use (BH/SU) benefits are administered by OptumHealth Behavioral Solutions and UnitedHealthcare. Employees who seek treatment for illegal substances should be aware that Delta's policy on the use of illegal drugs requires comprehensive treatment and participation in Delta's continuing care monitoring program. Search for and review the "Substance Abuse Recovery Program" and "Anti-Drug Program" HR Policies on Deltanet for information.

Your doctor must contact OptumHealth Behavioral Solutions to obtain Prior Authorization before receiving certain services for behavioral health/substance use treatment, as described in "Prior Authorization from OptumHealth Behavioral Solutions" later in this description of covered behavioral health/substance use services.

You can call OptumHealth Behavioral Solutions to talk with a trained clinical specialist 24 hours a day, seven days a week. The clinical specialist can help you choose a provider and the appropriate level of care. If your doctor notifies OptumHealth Behavioral Solutions and you use a Network Provider, the plan pays higher benefits. You may receive a list of Network Providers at no charge by contacting OptumHealth Behavioral Solutions at **800-533-6939** or by visiting **myuhc.com** to print one.

Inpatient facility-based mental health or substance use disorder treatment includes acute inpatient and residential treatment center services received for one continuous treatment plan. Below is a general description of residential treatment services (RTC). As with all mental health services, neurobiological disorder services (Autism Spectrum Disorder services) and/or substance use disorder services, the claims administrator applies certain standards and criteria when determining whether a certain treatment is covered by the Plan and the level of care which is covered.

RTC is a psychiatric or substance use disorder treatment program that provides 24 hour supervision, structure and treatment. Residential treatment is a short-term intervention to stabilize the presenting problem within a reasonable period of time. RTC is not intended to be for the purpose of providing respite for the family, protection from community influences, increasing the member's social activity, or for addressing anti-social behavior or legal problems, but is for active treatment of a behavioral condition. Wilderness programs, boys or girls ranch programs, or any other type of residential academic or recreational program with onsite behavioral health providers are generally not a Covered Service. The major indications for RTC placement are:

- Severely impaired functioning at home, school, and/or the community due to psychiatric illness or substance use, signaling the need for hospitalization if aggressive treatment is not provided
- Behavior is risky or out-of-control, requiring medical supervision and treatment 24 hours a day
- Many avenues of treatment have been pursued over time with minimal or no benefit. The therapist is recommending a higher level of care
- Hospitalization due to a suicide attempt, violent behavior, or other serious behavioral/emotional symptoms and is not yet ready to return home

Before you decide to be admitted to an RTC, call OptumHealth Behavioral Solutions at **800-533-6939** (or Delta Health Direct at **877-912-1820** and choose the OptumHealth Behavioral Solutions prompt) and discuss the situation with a Care Advocate **prior to admission**. The Care Advocate will address Network options, as well as your benefit plan, medical necessity and continuing stay guidelines for an RTC program. **Note: If coverage is denied for an RTC program, the denial applies to both Network and Non-Network services.** By speaking with the Care Advocate, you may avoid high out-of-pocket costs if the RTC is not approved. The Care Advocate can assist with finding alternate care quickly.

Outpatient mental health or substance use disorder treatment includes facility-based intensive outpatient program services, facility-based partial hospitalization programs, individual and group counseling and medication management provided by a licensed practitioner (psychiatrist, psychologist, social worker or licensed professional counselor).

Neurobiological Disorders – Autism Spectrum Disorder Services

All of the DABHP medical plan options pay benefits for behavioral services for Autism Spectrum Disorder, including intensive behavioral therapies* such as Applied Behavior Analysis (ABA) that are:

- Focused on treatment of core deficits of Autism Spectrum Disorder
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision, and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

Benefits include the following levels of care:

- Inpatient treatment (covered on a semi-private room basis)
- Partial hospitalization/day treatment
- Residential treatment
- Intensive outpatient treatment
- Outpatient treatment

OptumHealth Behavioral Solutions determines coverage for all levels of care.

The services described here are only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of this disorder may be covered under the applicable medical Covered Services described in this handbook.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Crisis intervention
- Provider-based case management services

Prior Authorization from OptumHealth Behavioral Solutions

Your doctor should contact OptumHealth Behavioral Solutions at **800-533-6939** (or Delta Health Direct at **877-912-1820** and choose the OptumHealth Behavioral Solutions prompt) to obtain Prior Authorization before you receive the following services or supplies for mental health services, neurobiological disorder services (Autism Spectrum Disorder services) and/or substance use disorder services:

- A scheduled in-patient admission (for emergency admissions, see “When to Notify Delta Health Direct (Prior Authorization Not Required)” earlier in this “Medical Benefits” section
- Partial hospitalization/day treatment and services at a residential treatment facility

* Intensive behavioral therapy is outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders.

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- Intensive outpatient program treatment
- Outpatient electro-convulsive treatment
- Extended outpatient treatment visits beyond 45 – 50 minutes in duration, with or without medication management
- Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA)

If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied. OptumHealth Behavioral Solutions does not authorize or accommodate care by unqualified providers. Note that for outpatient treatment (other than those listed above), Prior Authorization from OptumHealth Behavioral Solutions is generally not required; however, you are strongly encouraged to notify OptumHealth Behavioral Solutions prior to receiving care.

Under all plans, for inpatient confinements, OptumHealth Behavioral Solutions must be contacted:

- For non-Emergency (elective) admissions, at least five days before of the scheduled admission date
- For Emergency (non-elective) admissions, as soon as reasonably possible. Notification is required within two business days of admission, if reasonably possible, after you are admitted to a non-network hospital as a result of an Emergency, or the applicable expenses will be denied.

In addition to all other exclusions listed in the “What the Medical Plans Do Not Cover” section of this handbook, the exclusions listed below apply to services described under this *Behavioral Health and Substance Use Disorder Treatment and Neurobiological Disorders - Autism Spectrum Disorder Services* section:

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction
- Transitional living services

Birth Control Pills

Birth control pills are covered as a prescription drug benefit. In addition, over-the-counter contraceptives that are FDA approved and prescribed by a health care provider are covered, such as contraceptive sponges or spermicides; however, contraceptives for men are not covered.

For the HRA, OOA HRA, Gold HSA, Silver HSA, Bronze HSA, OOA Gold HSA, Retiree & Survivor Bronze HSA, Retiree & Survivor Bronze OOA HSA or Puerto Rico OOA, Tier I oral contraceptives are covered at 100%. For a list of the Tier 1 oral contraceptives that are available at no cost, refer to your applicable Prescription Drug Lists (PDL). You can view the PDL on Benefits Direct on Deltanet. You can also access the drug list at myuhc.com.

Blood/Plasma Preservation

This is covered for the purpose of preservation of autologous blood products for scheduled surgery for up to 30 days.

Breast Cancer Susceptibility Test (BRCA 1 and BRCA 2)

BRCA1 and BRCA2 is genetic testing for hereditary breast and/or ovarian cancer (HBOC) syndrome. The applicable Deductible and Coinsurance apply.

Coverage of such testing is subject to Prior Authorization review. You or your doctor must call Delta Health Direct at **877-912-1820** prior to testing. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Genetic counseling and evaluation for BRCA testing is covered as Preventive Care under healthcare reform legislation for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. This means the services are covered at 100% with no Deductible or Coinsurance.

Breast Pumps

As required by healthcare reform law, Preventive Care benefits defined under the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services include the cost of renting or purchasing one breast pump per pregnancy in conjunction with childbirth. When enrolled in the HRA, OOA HRA, Gold HSA, Silver HSA, Bronze HSA, OOA Gold HSA, Retiree & Survivor Bronze HSA, Retiree & Survivor Bronze OOA HSA or the Puerto Rico OOA, coverage is provided only if breast pumps are rented or purchased from a Network Durable Medical Equipment (DME) provider or physician.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UHC will determine:

- Which pump is the most cost effective
- Whether the pump should be purchased or rented
- Duration of a rental
- Timing of an acquisition

Breast Reconstruction or Reduction Surgery

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry are covered under the Plan. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Breast surgery considered cosmetic is not covered by the Plan. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about benefits for mastectomy-related services.

Breast reconstruction, including reconstructive surgery following a mastectomy or reduction surgery requires Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820**. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

These breast reconstruction surgeries are subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits under the plan. For more information on these WHCRA benefits, call Delta Health Direct at **877-912-1820**.

Cancer Treatment – URN Cancer Resource Services (CRS) Facility

The plan pays benefits for oncology services provided at a designated facility participating in the Cancer Resource Services (CRS) program. Eligible services are covered at 100% (after the Deductible) of the Network Charges when using a Center of Excellence and when enrolled in the CRS program. If using a URN Cancer Resource Facility that is not a Center of Excellence, eligible expenses are covered at plan level coinsurance. For oncology services and supplies to be considered Covered Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. Palliative care is covered for all cancer diagnoses and does not have to be associated with hospice care.

If you or a covered dependent has cancer, you may:

- Be referred to CRS by a Personal Health Support Nurse;
- Call Delta Health Direct at **877-912-1820**; or
- Visit **www.myoptumhealthcomplexmedical.com**

Travel and lodging for the patient and one family member acting as a travel companion, up to a \$10,000 lifetime limit, is covered by the plan when a UnitedHealthcare URN Cancer Resource Services (CRS) Facility provides the treatment. You or your doctor must notify Delta Health Direct at **877-912-1820** in advance before you incur any travel and lodging expenses related to your cancer treatment at a URN Cancer Resource Services Facility.

Cancer Treatment – Non-URN Cancer Resource Services (CRS) Facility

Cancer treatment is considered a Covered Service and is covered at the plan level Coinsurance; however, when a non-URN Cancer Resources Facility performs the treatment, travel and lodging are not covered by the plan. For oncology services and supplies to be considered Covered Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. Palliative care is covered for all cancer diagnoses and does not have to be associated with hospice care.

Cardiac and Pulmonary Rehabilitation Therapy

The plan covers eligible therapy services that meet the definition of a Covered Service. A licensed therapy provider, under the direction of a physician (when required by state law), must perform the services.

Cardiac and pulmonary rehabilitation therapy coverage is limited to 30 combined network and non-network visits per calendar year per type of therapy.

After the limit has been met, additional visits are subject to medical review. You or your doctor should notify UHC of your request for additional therapy visits by calling Delta Health Direct at **877-912-1820**.

Chemotherapy

Outpatient chemotherapy treatment is considered a Covered Service.

Chiropractic Care

The charges are covered when the charges are for the treatment of a non-occupational illness, injury or disease. The Chiropractic Clinical Support Program will work with your provider to understand the frequency of care needed or if alternate care should be considered in addition to or in lieu of chiropractic care.

There is a maximum of 20 visits per year for an adult. All treatment beyond 20 visits per calendar year is not covered.

Massage therapy is not covered.

For the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, chiropractic care provided by a Non-Network Provider is not a Covered Service.

Cochlear Implants

Expenses for cochlear implants are considered covered for patients with moderate to profound bilateral sensorineural hearing loss. Potential candidates for cochlear implant must obtain limited benefit from hearing aids, which typically is determined by administering age appropriate word/sentence recognition testing while the patient wears appropriately fitted hearing aids, often described as the best-aided condition. Cochlear implants may be considered for use in patients who acquired hearing loss after development of speech (postlingual), during development of speech (perilingual) or before development of speech (prelingual).

Colonoscopy – Diagnostic or Preventive

Colonoscopies, including fecal DNA testing for colon cancer screening, for diagnostic purposes or for routine/preventive care are considered eligible expenses when deemed to be necessary and ordered by your doctor.

A covered preventive/routine colonoscopy is based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for preventive services for women, infants, children and adolescents, and the Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC). See "Preventive Care" later in this section for information on how to access these recommendations.

Under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, one preventive or diagnostic colonoscopy per calendar year, as well as the colonoscopy consultation, is paid at 100%, not subject to the Deductible; however, they are not covered if performed by a Non-Network Provider. Subsequent colonoscopies in the same calendar year are subject to the annual Deductible and Coinsurance.

For the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or Puerto Rico OOA, the first colonoscopy in a calendar year, as well as the colonoscopy consultation, is covered at 100%, not subject to the Deductible, even if performed by a Non-Network Provider. Subsequent colonoscopies in the same calendar year are subject to the annual Deductible and Coinsurance.

Routine colorectal cancer screening is recommended beginning at age 50; however, you may need to be screened earlier if you are at higher risk due to a close family history of colon polyps or cancer, for example. Speak with your physician to see what's appropriate for you.

Congenital Heart Disease Surgery

The medical plan pays benefits for congenital heart disease (CHD) surgeries which are ordered by a physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

You or your physician/healthcare provider must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** prior to any CHD surgical procedure. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan.

Contact Lenses

Contact lenses or scleral shells that are used to treat an injury or disease (e.g., corneal abrasion or keratoconus) may be covered as a therapeutic service.

Cranial Remodeling Helmet for Treatment of Congenital MSK Deformities

Cranial remodeling helmet is an orthotic device that treats craniofacial asymmetry and covered by the Plan.

Dental Services Covered by This Medical Plan: Accident or Medical Condition Related

Accident-related dental services are considered a Covered Service when all of the following are true:

- Treatment is necessary because of accidental damage
- Dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth
- Dental services are received from a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD)
- The dental damage is severe enough that initial contact with a physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.)

Dental services for final treatment to repair the damage caused by accidental injury must be started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The medical plan pays for treatment of accidental injury only for:

- Emergency examination
- Necessary diagnostic x-rays
- Endodontic (root canal) treatment
- Temporary splinting of teeth
- Prefabricated post and core
- Simple minimal restorative procedures (fillings)
- Extractions
- Post-traumatic crowns if such are the only clinically acceptable treatment
- Replacement of lost teeth due to the injury by implant, dentures or bridges

The plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system)
- Direct treatment of acute traumatic injury, cancer or cleft palate

If you are enrolled in a network option (HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA), and you need to see a specialty provider for accident-related dental services but there is no Network Provider and/or facility within a 30-mile radius of your home ZIP Code, you may be eligible to receive benefits for certain Covered Services by a Non-Network Provider within that specialty at the network level. All benefits that fall under this category must be approved prior to receipt of care and are subject to any plan limitations or exclusions set forth in this handbook. You must call Delta Health Direct at **877-912-1820** to obtain such approval.

If you or a dependent is enrolled in one of Delta's dental options, see the "Dental Benefits" section of this handbook for information about other dental care coverage.

Depo-Provera

Depo-Provera is covered at 100% under the Preventive Care benefit as required by healthcare reform. If enrolled in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, Preventive Care is covered only when using a Network Provider. Note that Depo-Provera is covered under both the medical and prescription drug benefits to allow you to pick up the device at the pharmacy or your physician's office. Prescription drugs are only covered if you obtain them from a network pharmacy. Services to implant the medication are also considered medical Covered Services.

Dialysis

Inpatient and outpatient dialysis treatment is considered a Covered Service; however, in some options dialysis treatment is covered only if performed in-network.

Dialysis must be performed at a network facility to be considered a Covered Service under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA. If enrolled in the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or the Puerto Rico OOA, you may go to a network or non-network facility for treatment.

Diaphragm – Device and Fitting

Diaphragms are covered at 100% under the Preventive Care benefit required by healthcare reform. If enrolled in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, Preventive Care is covered only when using a Network Provider. Coverage includes the device, fitting and removal. Note that diaphragms are covered under both the medical and prescription drug benefits to allow you to pick up the device at the pharmacy or your physician's office.

Disposable Diabetic Supplies

Under the DABHP Medical Options, diabetic supplies are covered at 100%, not subject to the Deductible, through a mail order program administered by Byram Healthcare/Edgepark/OptumRx™/Medtronic. There is no benefit for disposable diabetic supplies if the Byram Healthcare/Edgepark/OptumRx™/Medtronic mail order program is not used. Supplies eligible for this program may include blood glucose meters, test strips, syringes and needles, lancets, alcohol swabs, control solution for meters, diabetic pump supplies (excluding pumps) and educational materials. Prescriptions for insulin and oral medications used for the treatment of diabetes are covered by the prescription drug benefit, and can be filled through UHC mail order or at a network retail pharmacy. You can reach Byram Healthcare/Edgepark/OptumRx™/Medtronic by calling **877-902-9726/800-321-0591/877-912-1820/888-472-9076**.

Disposable Medical Supplies – Inpatient/Outpatient

Consumable/disposable medical supplies used while in an inpatient or outpatient hospital setting are considered Covered Services.

Disposable Medical Supplies – Retail

The retail purchase of disposable medical supplies is considered a Covered Service. This includes ostomy, dialysis supplies, tracheal supplies and home use catheters. Home use supplies (such as gauze, medical tape and alcohol/peroxide) are not covered under the plan.

Durable Medical Equipment (DME)

DME is a Covered Service if (1) it is used primarily for medical purposes; (2) it is for repeated use; (3) it is not a consumable or disposable item; and (4) it is appropriate for use in the home. Rental of DME and surgical equipment is covered, unless it is more economical to purchase the equipment. Replacements must be Covered Services.

Examples of covered DME include, but are not limited to: crutches, hospital beds, monitoring devices, oxygen tents, respirators or other equipment for the use of oxygen, prosthetic appliances, walkers, wheelchairs and other items as determined eligible by the claims administrator. Compression hose are not covered under the plan.

One rented or purchased breast pump per pregnancy is covered at 100% under the Preventive Care benefit as required by healthcare reform. If enrolled in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, Preventive Care is covered only when using a Network Provider. If you cannot obtain necessary supplies from a Network Provider, you can visit another network supplier, wait until the item is available, or contact Delta Health Direct at **877-912-1820** to obtain authorization for reimbursement at the network benefits level from a Non-Network Provider.

Each short-term rental or purchase of DME costing more than \$1,000 requires Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820**. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan.

Emergency Care and Urgent Care

A true Emergency is a sudden and severe medical condition, illness or injury (including, but not limited to, severe pain) that, if not treated immediately, could cause seriously impaired function, serious dysfunction of a bodily organ or part, or death, or in the case of pregnancy, serious jeopardy to the health of the fetus. In the judgment of a reasonable person, an Emergency requires immediate care and treatment to avoid jeopardy to life or health.

Some examples of true Emergencies include:

- Loss of consciousness
- Uncontrolled bleeding
- Poisoning or suspected overdose of medication
- Severe burns
- Severe shortness of breath
- Chest pain or oppressive squeezing in the chest
- Stroke symptoms (numbness or paralysis of an arm or leg, suddenly slurred speech, lack of responsiveness, severe headache)

In an Emergency, seek care immediately. You should call an ambulance or a police emergency number, or you should go directly to a hospital.

To receive network benefits, services must be provided by a Network Provider or at a network hospital or facility. Non-network services or charges are paid as Network Charges if the condition is a true Emergency, as described earlier. For follow-up care, to receive network benefits, services must be provided by a Network Provider. If admitted to the hospital from the emergency room, Notification to UHC by calling Delta Health Direct at **877-912-1820** is required as soon as reasonably possible. If

you are admitted to a non-network hospital as a result of an Emergency, Notification is required within two business days of admission, if reasonably possible. If UHC is not notified within the timeframe noted, the charges will not be covered under the Plan.

If you seek care in the emergency room for a non-Emergency, the service will not be covered.

Urgent care is defined as not being a true Emergency, but a situation that requires prompt medical attention. Some examples of urgent situations include:

- Ear infections
- Excessive vomiting
- High fever
- Minor burns
- Prolonged diarrhea
- Severe stomach pain

An urgent care center is a healthcare facility that is organizationally and financially separate from a hospital, and whose primary purpose is to provide immediate, short-term medical care.

FAA Flight Physicals

FAA flight physicals are not covered by the DABHP. Delta pilots should contact the Chief Pilots Support Center at **404-715-1323** or **877-DAL-2FLY** for information about reimbursement.

Gynecological Exam – Diagnostic

Gynecological exams for diagnostic purposes are considered eligible for covered expenses when deemed to be necessary and ordered by your doctor.

Gynecological Exam - Preventive

As provided by healthcare reform legislation, preventive/routine gynecological exams are based on the Health Resource and Services Administration (HRSA)–supported health plan coverage guidelines for women’s preventive services and are limited to one exam per year. See “Preventive Care” later in this section for information on how to access these guidelines.

Under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, if performed by Network Providers, annual gynecological exams are paid at 100%, not subject to the Deductible. Services are not covered if they are performed by a Non-Network Provider.

If you are enrolled in the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or Puerto Rico OOA, annual gynecological exams are paid at 100%, not subject to the Deductible, even if performed by a Non-Network Provider.

Home Healthcare

Covered Services are services that a home health agency (a program or organization authorized by law to provide health care services in the home) provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a physician
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse
- Not considered Custodial Care
- Provided on a part-time, intermittent schedule when skilled care is required

To help ensure that expenses are covered by the plan, you or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820**. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

UHC will decide if skilled care is needed by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Coverage will be reviewed throughout the duration for medical appropriateness.

Hospice Care

Hospice care is covered for a patient who, according to his or her doctor's diagnosis, has a terminal illness and is not expected to live more than six months. Care must be provided under a "hospice care program," which is a coordinated, interdisciplinary program to meet the physical, psychological and social needs of terminally ill patients and their families, and provides palliative and supportive medical, nursing and other health services during the illness. Hospice care services can be provided by a hospital, skilled nursing facility or similar institution, a home healthcare agency or a hospice facility.

You or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** before admittance of the patient to a hospice care facility is initiated. If you do not call to obtain Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

The following hospice care services, when provided under a hospice care program, are covered by the plan:

- Drugs, medicines and medical supplies for pain relief treatment provided by the hospice facility or home healthcare company
- Home health aid services and lab services to ease pain
- Outpatient hospice services
- Part-time or intermittent nursing care services by a home healthcare agency
- Professional services provided by a doctor, psychologist, licensed clinical social worker (LCSW) or family counselor for individual or family counseling
- Room and board, up to the facility's most common daily rate for a semi-private room and the medical services and supplies charged by the facility and actually used during a confinement

Covered hospice care does not include:

- Services provided by a family member, dependent's family member or another resident of your household
- Services not listed in the hospice care program
- Services for curative or life-prolonging purposes
- Services for which any other benefits are payable under the plan
- Services or supplies primarily to aid daily living
- Bereavement counseling
- Respite care
- Nutritional supplements, non-prescription drugs or substances

Hospital Care — Inpatient and Outpatient Services

The plan covers eligible medical and surgical charges by a hospital or other approved facility for inpatient and outpatient services and supplies provided for a non-occupational illness, injury or condition, including preadmission testing. Outpatient surgeries performed in a hospital incur a \$250 place of service surcharge (see "Place of Service Surcharge "below for details). Charges for an inpatient hospital admission and associated fees are covered if they are determined to be Medically Necessary during the Prior Authorization process.

The plan pays for semi-private or intensive care unit room and board during an authorized hospital confinement. If a semi-private room is not available, the Delta medical plans cover up to the average semi-private room rate charged by other hospitals in the same geographic area for a semi-private room alternative. The Delta medical plans also pay for necessary Covered Services and supplies, such as administration of anesthesia, medications and prescription drugs; lab, X-rays and other diagnostic services including MRIs; dressings and casts; physician-prescribed private-duty services of a registered nurse (RN) or licensed practical nurse (LPN) (outpatient only); and surgeries (including the use of operating rooms). Doctor, surgeon and anesthesiologist services, and other medical professional services performed while in the hospital or in conjunction with the use of outpatient facilities, are also considered Covered Services, unless specifically excluded.

The plan also provides benefits for hospital charges and anesthetics provided for dental care for pediatric members and children, regardless of age, who are incapable of self-support due to mental or physical handicaps if the handicap occurred before meeting the plan's maximum age limit and medically necessary as determined by UHC.

You or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** before the following hospital inpatient services:

- For non-Emergency (elective) admissions, at least five days before of the scheduled admission date
- For maternity inpatient confinement related to delivery of child (for either the mother or the child) that continues beyond the 48- to 96-hour limits

Delta Health Direct must be contacted for Prior Authorization only if the inpatient care for the mother or child is expected to continue beyond 48 hours following vaginal delivery or 96 hours following a cesarean section. Under federal law, you do not have to get pre-approval for a maternity admission if your expected hospital stay is 48 hours or fewer for a normal delivery, or 96 hours or fewer for a cesarean section. See the "Plan Administration and Legal Rights" section of this handbook for details

- Non-Emergency maternity inpatient confinement without delivery of child
 - Confinement during pregnancy, but before the admission for delivery, that is not Emergency Care requires Prior Authorization as a scheduled inpatient admission

Prior Authorization is also required for the following outpatient surgeries: arthroscopy, hysterectomy, sinuplasty, cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implants, sleep apnea surgeries, orthognathic surgeries, and for selected infusions of anti-inflammatory/immune modulator medications covered under the medical benefit when administered in an outpatient hospital setting. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Place of Service Surcharge

The HRA, Gold HSA, Silver HSA, Bronze HSA and Retiree & Survivor Bronze HSA Medical Options include a \$250 "place of service surcharge" that applies to outpatient Major Diagnostics – CT scans, PET scans, MRIs, MRAs, nuclear medicine and major diagnostic services – if these procedures are not done at a free-standing facility. This \$250 place of service surcharge also applies to outpatient surgeries that are performed in a hospital. This surcharge may be avoided by making sure that the facility where these outpatient services are received is independently run, not managed, billed or otherwise associated with a hospital. This surcharge does not apply to labs and X-rays unless they are done in conjunction with an outpatient surgery at a hospital.

This \$250 place of service surcharge applies to Network and Non-Network Services and must be paid in addition to the annual Deductible and Coinsurance amount. However, place of service surcharges that you pay count towards the Annual Out-of-Pocket Maximum and will not apply once the Annual Out-of-Pocket Maximum is reached.

For assistance in locating a free-standing facility, please contact Delta Health Direct at **877-912-1820**.

Immunizations for Adults and Children

Immunizations are covered according to the Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention. See "Preventive Care" later in this section for information on how to access these guidelines.

Immunizations under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA are covered at 100%, not subject to the Deductible, when performed by a Network Provider. Immunizations are not covered if performed by a Non-Network Provider. Under the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA and Puerto Rico OOA, immunizations are covered at 100%, not subject to the Deductible, even if performed by a Non-Network Provider.

Under all DABHP options, travel health consultations and extra doctor's charges are not covered as part of the 100% Preventive Care benefit; however, travel immunizations are covered under the DABHP Medical Options.

Infertility Treatments

The plan covers the initial diagnosis and treatment to identify underlying systemic conditions that may be the cause of infertility. The plan does not cover infertility procedures such as artificial insemination, in-vitro fertilization, GIFT, ZIFT, cloning, micro-injection techniques, other assisted reproduction technologies, injectable or oral infertility drug treatments, or any other process associated with these procedures.

For information on the "ParentSteps" Infertility Discount Program, look for this program outlined under the "Medical Plan Programs" section earlier in this "Medical Benefits" section.

Intensity Modulated Radiation Therapy

Intensity Modulated Radiation Therapy (IMRT) is a high-precision radiation therapy that delivers precise radiation doses to a malignant tumor, while minimizing the radiation dose surrounding organs and tissue. This technique is more complex and expensive than conventional radiation therapy. Both conventional radiation therapy and IMRT are effective for cancer control, but IMRT is necessary ONLY for special conditions that require more precision. Current use of IMRT is proven for cancers related to the head, neck, prostate, central nervous system, certain types of breast cancer and a limited number of other clinical scenarios.

IUD

As required by healthcare reform, IUDs are covered under the Preventive Care benefit. Coverage includes the device, fitting and removal. If you are enrolled in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, and use a Network Provider, coverage is 100%. If you use a Non-Network Provider, the IUD device, fitting and removal are not covered by the plan. Coverage is 100% for those enrolled in the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA and Puerto Rico OOA, regardless of the provider's network status.

Laboratory Work and Tests – Diagnostic

The plan covers diagnostic laboratory services performed in a lab facility, office or clinic. Diagnostic lab work and tests ordered by a Network Provider are considered covered network services even if the services are performed in a non-network facility.

Outpatient sleep studies require Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820**. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan.

Laboratory Work and Tests – Preventive Care

Covered preventive laboratory expenses are based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for preventive services for women, infants, children and adolescents, and the Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC). See "Preventive Care" later in this section for information on how to access these recommendations.

Under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, preventive laboratory work and tests are covered at 100%, not subject to the Deductible, when performed by a Network Provider. Preventive laboratory work and tests are not covered if performed by a Non-Network Provider. For the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA and Puerto Rico OOA, preventive laboratory work and tests are covered at 100%, not subject to the Deductible, even when performed by a Non-Network Provider.

Major Diagnostics – CT, PET Scans, MRI, MRA and Nuclear Medicine

Covered Services include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a hospital, alternate facility or in a physician's office. Benefits include the facility charge and the charge for supplies and equipment, and physician services for radiologists, anesthesiologists and pathologists.

You or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** before you receive a CT scan, PET scan, MRI, MRA or nuclear medicine including diagnostic catheterization and electrophysiology implants. If you do not receive this Prior Authorization or if the service is not authorized, the service is not covered by the Plan and you will be responsible for paying all charges. Additionally, if some of the services being requested are not approved, the applicable expenses are not covered.

Place of Service Surcharge

The HRA, Gold HSA, Silver HSA, Bronze HSA and Retiree & Survivor Bronze HSA Medical Options include a \$250 "place of service surcharge" that applies to outpatient Major Diagnostics – CT scans, PET scans, MRIs, MRAs, nuclear medicine and major diagnostic services – if these procedures are not done at a free-standing facility. This \$250 place of service surcharge also applies to outpatient surgeries that are performed in a hospital. This surcharge may be avoided by making sure that the facility where these outpatient services are received is independently run, not managed, billed or otherwise associated with a hospital. This surcharge does not apply to labs and X-rays unless they are done in conjunction with an outpatient surgery at a hospital.

This \$250 place of service surcharge applies to Network and Non-Network Services and must be paid in addition to the annual Deductible and Coinsurance amount. However, place of service surcharges that you pay count towards the Annual Out-of-Pocket Maximum and will not apply once the Annual Out-of-Pocket Maximum is reached.

For assistance in locating a free-standing facility, please contact Delta Health Direct at **877-912-1820**.

Mammograms – Diagnostic or Preventive

Mammograms, including 3D mammograms, and ultrasounds for diagnostic purposes or for routine/preventive care are considered eligible expenses when deemed to be necessary and ordered by your doctor.

A covered preventive/routine mammogram is based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for preventive services for women, infants, children and adolescents, and the Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC), See "Preventive Care" later in this section for information on how to access these recommendations.

Under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, one preventive mammogram and ultrasound per year are covered at 100%, not subject to the Deductible, when performed by a Network Provider. Preventive mammograms are not covered if performed by a Non-Network Provider. If medically necessary, an additional mammogram and/or ultrasound (for a maximum of four services in the same calendar year) is covered at 100% if age 21 or older, when performed by a Network Provider. Subsequent mammograms and/or ultrasounds in the same calendar year are subject to the annual Deductible and Coinsurance.

For the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA and Puerto Rico OOA, one preventive mammogram and ultrasound per year are covered at 100%, not subject to the Deductible, even when performed by a Non-Network Provider. If medically necessary, an additional mammogram and/or ultrasound (for a maximum of four services in the same calendar year) is covered at 100% if age 21 or older. Subsequent mammograms in the same calendar year are subject to the annual Deductible and Coinsurance.

Routine mammograms are recommended for women every one to two years beginning at age 40, or as directed by your physician; however, you may need to be screen earlier or more frequently if you are at higher risk. Speak with your physician to see what is appropriate for you or about breast cancer prevention alternatives with low risk of adverse side effects.

Maternity Care – Physician Services and Facility Services Including Birthing Center

Medical, surgical and hospital care are covered during the term of the pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous and legal therapeutic abortions, and complications of pregnancy.

Maternity services include:

- Hospital expenses, including nursery charges for the newborn child
- Obstetrical fees for normal delivery, cesarean section, abdominal operation for extra-uterine pregnancy or miscarriage
- Certified or licensed nurse midwife services performed under a physician's supervision in an approved facility
- Diagnostic testing during pregnancy
- Pre- and postnatal care of the mother
- Maternity care for the dependent child of a covered employee
- Charges for circumcision

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to fewer than 48 hours following a vaginal delivery or fewer 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 newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay less than 48 hours (or 96 hours). Accordingly, if the mother's or the newborn's length of stay exceeds 48 hours (or 96 hours if a cesarean section), Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** is required. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

MR-Guided Focused Ultrasound

A system used for treatment using a high intensity focused ultrasound beam that heats and destroys targeted tissue. Combined with Magnetic Resonance Imaging which provides a visual of the patient's anatomy to help control the treatment in progress.

Newborn Care

Under the DABHP options, a newborn dependent child is covered for preventive care, well baby care or other Covered Services for the first 31 days following birth, or for the first four days following birth of a grandchild when the mother is a covered dependent daughter. For coverage to extend past this time, the newborn child must be enrolled in coverage as a dependent no later than 60 days following birth.

Nutritional/Dietary Supplements

These supplements are covered if they are the only form of sustenance.

Nutritionists/Dieticians

Nutritional counseling is a covered service. For preventive and non-preventive nutritional counseling, services are covered at a Network Provider or Non-Network Provider. Coverage is limited to six visits per calendar year. With clinical review, three additional visits per condition are also available. For nutritional counseling related to weight management or bariatric surgery, services are covered at a Network Provider only.

Office Visits – Primary Care Physicians and Specialists

The plans cover charges for visits to a doctor's office, or a doctor's (an internist, general physician, family practitioner, pediatrician and specialist) visit to your home, for diagnosis, care and treatment of illness or injury, in connection with pregnancy, for Preventive Care (as outlined in the "Preventive Care" entry of this list of Covered Services), as well as care related to other Covered Services, such as diagnostic lab and X-ray work performed during a visit.

Oral Surgery

Some oral surgery is considered a medical expense, while other oral surgery is considered a dental expense. In some cases, charges are split between medical and dental benefits — meaning that some portions of the charge may be considered for payment under your dental option, while other portions may be considered under your medical option.

Before you undergo any oral surgery procedure, you and/or your doctor/dental specialist should request a pretreatment estimate from MetLife and/or a predetermination from UHC. If you need further information or clarification, you can contact Delta Health Direct at **877-912-1820** or the MetLife Dental Customer Service Center at **855-700-7992**.

Organ Transplants – United Resource Networks (URN) Facility

The plan covers charges for, or in connection with, approved organ transplant services, including immunosuppressive medication, organ procurement costs related to procurement of an organ, and the donor's medical costs.

UHC offers the United Resource Network (URN) in association with organ and tissue transplant services. Participation in the URN program is required for services to be covered by the plan. Organ transplant services when a non-URN organ transplant facility performs the service is not a Covered Service under the plan and will not apply to your Deductible or Annual Coinsurance Maximum (or Annual Out-of-Pocket Maximum in the Puerto Rico OOA option).

Travel and lodging for the patient and one family member acting as a travel companion, up to a \$10,000 lifetime limit, is covered by the plan when a UnitedHealthcare URN Organ Transplant Facility provides the services. Also, eligible services performed as part of the URN program are covered at 100% of the Network Charges, after the Deductible.

You or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** before you are hospitalized for an organ transplant in an URN facility or before you incur any travel and lodging expenses related to your transplant, if you plan on using the travel and lodging benefit. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Orthognathic Surgery

The plan covers orthognathic surgery which is the surgical correction of skeletal anomalies or malformations involving the mandible (lower jaw) or the maxilla (upper jaw).

You or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** before your orthognathic surgery is performed. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Orthoptic Training

Medical services for orthoptic training (exercise for the eye muscles) are considered Covered Services when medically and ordered by your doctor.

Pain Management

Medical services for pain management are considered Covered Services as long as they are for the direct care of the patient. Educational services or group therapy are not covered.

Podiatry Care

Podiatry care is covered when necessary for the treatment of a disease or illness of the foot. One pair of custom made orthotic shoe inserts per calendar year is covered for arch, heel or other foot pain, diplegic cerebral palsy, juvenile idiopathic arthritis, pes cavus (high arch), plantar fasciitis, and rheumatoid arthritis. Orthotic shoes, routine foot care and preventive foot care are not covered.

Prescription Drugs

The term "prescription drugs" means a medication, product or device that has been approved by the Food and Drug Administration and can, under federal or state law, be dispensed only by direction of a prescription order or refill for the treatment of an injury or an illness.

The Plan provides you with prescription drug benefits through UHC's Prescription Drug List (PDL) or, for the HRA and HSA Medical Options, the Preventive Drug list. The PDL is a comprehensive list of covered drugs and injectable medications. You can view the Preventive Drug list or the PDL on Deltanet. You can also access the drug list at **myuhc.com**.

Your doctor must obtain prior authorization from OptumRX™ before you receive a compound drug over \$50 or for you to receive a breast cancer preventive drug with no cost-sharing as Preventive Care services under healthcare reform legislation for women whose family history is associated with an increased risk of breast cancer.

Prior authorization may be required for members who meet specific coverage criteria for certain statins to be covered at 100%. See "Statins for Primary Prevention of Cardiovascular Disease" in a particular Delta medical option's description in this "Medical Benefits" section.

For specific coverage details, turn to a particular Delta medical option's description in this "Medical Benefits" section to review the "Prescription Drug" information.

Preventive Care – Routine Physicals, Women’s Preventive Services, Colonoscopies, Well Child Visits

Preventive Care coverage is provided for the most common conditions that threaten your health — those that, if detected early enough, can be effectively treated.

The Plan covers Preventive Care services in accordance with U.S. Preventive Services Task Force (USPSTF) Grade A and B guidelines, the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for preventive services for women, infants, children and adolescents, and the Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC).

To see a summary of which Preventive Care services are recommended for various age groups, review the preventive care guidelines on the USPSTF website at www.uspreventiveservicestaskforce.org. For a complete list of recommendations, please visit the following government websites:

- <http://www.ahrq.gov/clinic/uspstfix.htm>,
- <http://www.hrsa.gov/womensguidelines/>,
- <http://www.cdc.gov/vaccines/schedules/index.html>, and
- <http://www.cdc.gov/vaccines/pubs/acip-list.htm>

The health care reform law requires plans to cover the obesity screening and counseling for those with a BMI of 30+ at no cost-share. Please note that weight management programs, such as Weight Watchers®, are not covered under this benefit.

Additional services that are categorized as preventive services and covered at 100% when provided by a Network Provider include:

- Depression screening for adults
- Depression screening for adolescents
- Aspirin preventive medication for adults aged 50-59 years with a 10% or greater, 10-year cardiovascular risk
- Syphilis screening for non-pregnant persons
- Colorectal cancer screening
- Tuberculosis screening for adults
- Statin preventive medication for adults who are 40-75 years old with no history of cardiovascular disease (CVD), 1 or more CVD risk factor and a calculated 10-year CVD event risk of 10% or greater (pre-authorization may be required – for specific coverage details, turn to a particular Delta medical option’s description in this “Medical Benefits” section to review the “Prescription Drug” information)

Additionally, the following shingles vaccines are categorized as preventive services and covered at 100% when provided by a Network Provider:

- Shingrix: Beginning at age 50
- Zoster: Beginning at age 60 (if between the ages of 50 – 59, the Plan covers the Zoster vaccine as a medical service)

HEALTHCARE BENEFITS HANDBOOK

Women's Preventive Care services include the following services or supplies. If you are in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, the services and supplies have to be provided by a Network Provider to be covered:

- Prenatal and postnatal breast-feeding support, counseling and supplies, including costs for renting or purchasing specified breast-feeding equipment
- Breast cancer prevention counseling strategies for women at a high risk
- Cervical cancer screening
- Domestic violence screening and counseling
- FDA-approved contraception methods administered by a provider; sterilization procedures as well as patient education and counseling for women participants with reproductive capacity
- Gestational diabetes screening for all pregnant women
- HIV counseling and screening for all sexually active women
- Human papillomavirus DNA testing for all women 30 years and older
- Osteoporosis screening for certain populations
- Sexually transmitted infection counseling for all sexually active women annually
- Well-woman visits including pre-conception counseling and routine prenatal care

Contact Delta Health Direct at **877-912-1820** if you have questions about Preventive Care or the expanded list of women's Preventive Care services.

Under the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, these Preventive Care services performed by a Network Provider are covered at 100%, not subject to the Deductible. Preventive Care services are not covered under these options if they are performed by a Non-Network Provider. Please note that if you are seeking Preventive Care and are unable to find a network provider, visit **myuhc.com** or contact Delta Health Direct at **877-912-1820** for assistance. If through this process of working with UnitedHealthcare, you collaboratively cannot locate a network provider to perform a Preventive Care service, the plan is required to cover that visit at 100%. *Understand that in this situation, however, you need to contact UHC **before** going to the doctor for your Preventive Care visit to confirm if it will be covered by the plan; there is no guarantee of payment otherwise.*

If you are enrolled in the OOA HRA, OOA Gold HSA, Retiree & Survivor Bronze OOA HSA or the Puerto Rico OOA, charges for these Preventive Care services are covered at 100%, not subject to the Deductible, even if performed by a Non-Network Provider.

Please note that annual preventive exams are covered once per calendar year. You do not have to wait 365 days between your last annual preventive exam to have the next annual preventive exam. For example, if you had your last annual physical on November 15th, you may schedule your next annual physical anytime the following calendar year (if enrolled in a Delta option the following calendar year); you do not have to wait until November 16th for your next annual physical. Some physician offices will ask that your visits be scheduled 365 days apart; however, our plan is administered on a calendar year basis (January-December) rather than a 365 day calendar. Annual preventive exams scheduled less than 365 days apart will be covered by the plan if done in two different calendar years.

A summary of some of the Preventive Care recommendations appear on the following pages. These guidelines are subject to change. Before receiving care, it is recommended that you confirm the current guidelines on the USPSTF website at **www.uspreventiveservicestaskforce.org**.

HEALTHCARE BENEFITS HANDBOOK

For a complete list of recommendations, please visit the following government websites:

- <http://www.ahrq.gov/clinic/uspstfix.htm>,
- <http://www.hrsa.gov/womensguidelines/>,
- <http://www.cdc.gov/vaccines/schedules/index.html>, and
- <http://www.cdc.gov/vaccines/pubs/acip-list.htm>

PREVENTIVE CARE SCREENING GUIDELINES AND COUNSELING SERVICES* FOR

Adult Men

A preventive health visit can help you see how healthy you are now and help identify any health issues before they become more serious. You and your doctor can then work together to choose the care that may be right for you. The following information provides guideline recommendations for preventive care screenings and counseling to evaluate general health and development in men over age 18.

Recommended preventive care services for men include the following:**Wellness Examinations.**

Abdominal Aortic Aneurysm Screening for age 65 - 75 years who have ever smoked.

Alcohol Screening and Brief Counseling during wellness examinations. Brief counseling interventions for certain patients.

Blood Pressure Screening at each wellness examination. Certain patients may also require ambulatory blood pressure measurements outside of a clinical setting. Check with your doctor.

Cholesterol Screening for age 40 - 75 years**.

Colorectal Cancer Screening for age 50 - 75 years. Ask your physician about screening methods and intervals for screening.

Depression Screening for all adults, in a primary care setting.

Diabetes Screening for age 40 - 70 years who are overweight or obese**.

Falls Prevention Counseling during wellness examination, for community-dwelling older adults.

Healthy Diet Behavioral Counseling for persons with cardiovascular disease risk factors, in a primary care setting.

Hepatitis B Virus Infection Screening for persons at high risk.

Hepatitis C Virus Infection Screening one-time for adults born between 1945 - 1965, or persons at high risk.

Human Immunodeficiency Virus (HIV) Screening.

Immunizations which are FDA approved and have explicit ACIP recommendations for routine use.

Latent Tuberculosis Infection Screening for persons at increased risk.

Lung Cancer Screening with Low-Dose CT Scan for age 55 - 80 years with at least a 30-pack per year smoking history (requires prior authorization).

Obesity Screening and Counseling at each wellness examination. Certain patients may need medical nutrition therapy.

Sexually Transmitted Infections, Behavioral Counseling for adults who are at increased risk, in a primary care setting.

Skin Cancer, Behavioral Counseling during wellness examination, for young adults up to age 24 years.

Syphilis Screening for adults at increased risk.

Tobacco Cessation, Screening, Behavioral Counseling for adults who smoke, in a primary care setting (refer to pharmacy vendor for pharmacotherapy for tobacco cessation).

*These guidelines are based, in part, on the requirements of the Patient Protection and Affordable Care Act, and recommendations of the U.S. Preventive Services Task Force (USPSTF), U.S. Department of Health and Human Services and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions that may not be covered as a preventive benefit. These guidelines do not necessarily reflect the vaccines, screenings or tests that will be covered by your benefit plan. These clinical guidelines are provided for informational purposes only, and do not constitute medical advice. Preventive care benefits may not apply to certain services listed above. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card.

**The ages described above are guidelines per the USPSTF. However, Delta encourages employees and covered spouses to get these screenings annually, at all ages, as part of the Delta Health Rewards program. For more information, go to [Delta.com > HR > Benefits > Delta Health Rewards](#).

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PREVENTIVE CARE GUIDELINE IMMUNIZATIONS* FOR

Adult Men and Women

Immunizations may help protect against many illnesses and diseases. The following immunization schedule provided by the Centers for Disease Control and Prevention (CDC) will give you the recommendations for adults over age 18.

Recommended immunization schedule for adults aged 19 years or older by age group, United States, 2018.

Vaccine	19-21 years	22-26 years	27-59 years	60-64 years	≥ 65 years
Influenza	1 dose annually				
Td/Tdap	Substitute Tdap for Td once, then Td booster every 10 yrs				
MMR	1 or 2 doses depending on indication				
VAR	2 doses†				
Shingles (Zoster and Shingrix)				Age 60 – Zoster (2 doses) or Age 60 – Shingrix (1 dose)	
HPV-Female	3 doses				
HPV-Male	3 doses				
PCV13					1 dose
PPSV23	1 or 2 doses depending on indication				1 dose
HepA	2 or 3 doses depending on vaccine				
HepB	3 doses				
MenACWY or MPSV4	1 or more doses depending on indication				
MenB	2 or 3 doses depending on vaccine				
Hib	1 or 3 doses depending on indication				

Recommended for adults who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection.	Recommended for adults with additional medical conditions or other indications.	No recommendation.
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See [healthcare.gov/coverage/preventive-care-benefits](https://www.healthcare.gov/coverage/preventive-care-benefits) for U.S. Preventive Services Task Force recommendations on clinical preventive services.

YOUR TRAVEL VACCINATIONS ARE COVERED AT 100 PERCENT

The Delta Account-Based Healthcare Plan medical options also fully cover travel vaccinations for you and your covered dependents when those vaccines are administered by a UnitedHealthcare network provider. Some of the recommended (or required) travel vaccinations, such as diphtheria/pertussis/tetanus boosters, hepatitis A and B, measles, meningococcal meningitis and poliovirus vaccines, may be easily obtained from your primary care physician, The Emory Clinic at Delta or a convenience care clinic, like Minute Clinic®, because those vaccinations are also commonly used for the general population. Other travel vaccinations, which are more specific to travelers such as yellow fever and Japanese encephalitis are typically only available from specialized travel clinics.

* Additional information about the vaccines in this schedule, extent of available data, including a full list of footnotes and contraindications for vaccination is also available at [cdc.gov/vaccines](https://www.cdc.gov/vaccines) or from the CDC (RFP) Contact Center at 1-800-CDC-INFO (1-800-232-4636) in English and Spanish, Monday through Friday, 9 a.m. to 8 p.m. ET, excluding holidays. For a complete list of footnote references, please visit [cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf](https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf)

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

These clinical guidelines are provided for informational purposes only, and do not constitute medical advice. Discuss with your doctor how these guidelines may be right for you, and always consult your doctor before making any decisions about medical care. Preventive care benefits may not apply to certain services listed above. Always refer to your plan documents for your specific coverage.

PREVENTIVE CARE SCREENING GUIDELINES AND COUNSELING SERVICES* FOR Adult Women

Preventive care may help with early detection of disease. You and your doctor can work together to evaluate your health and choose the care that may be right for you. The following information provides guideline recommendations for preventive care screenings and counseling to evaluate general health and development in women over age 18.

Recommended preventive care services for women include the following:

Wellness Examinations, Well-Woman Visits including routine, low-risk prenatal visits.

Abdominal Aortic Aneurysm Screening for age 65 - 75 years who have ever smoked.

Alcohol Screening and Brief Counseling during wellness examinations. Brief counseling interventions for certain patients.

Bacteriuria Screening during pregnancy.

Blood Pressure Screening at each wellness examination. Certain patients may also require ambulatory blood pressure measurements outside of a clinical setting. Check with your doctor.

Breastfeeding Primary Care Interventions, Counseling, Support and Supplies during pregnancy and after birth. Includes personal use electric breast pump.

Cervical Cancer Screening (Pap Smear) for women age 21 - 65 years old.

Chemoprevention of Breast Cancer, Counseling for women at high risk of breast cancer, but low risk for adverse effects.

Chlamydia and Gonorrhea Infection Screening for sexually active women age 24 and younger, and older women at increased risk.

Cholesterol Screening for age 40 - 75 years**.

Colorectal Cancer Screening for age 50 - 75 years. Ask your physician about screening methods and intervals for screening.

Contraceptive Methods (Including Sterilizations) for FDA-approved methods of contraception for women, including patient education and counseling.

Depression Screening for all adults, in a primary care setting.

Diabetes Screening for age 40 - 70 years who are overweight or obese**.

Falls Prevention Counseling during wellness examination, for community-dwelling older adults.

Genetic Counseling and Evaluation for BRCA Testing, and BRCA Lab Testing (with prior authorization).

Gestational Diabetes Mellitus Screening during pregnancy.

Healthy Diet Behavioral Counseling for persons with cardiovascular disease risk factors, in a primary care setting.

Hepatitis B Virus Infection Screening for persons at high risk.

Hepatitis C Virus Infection Screening one-time for adults born between 1945 - 1965, or, persons at high risk.

Human Immunodeficiency Virus (HIV) Screening for all adults.

Human Papillomavirus DNA Testing for women age 30 - 65.

Immunizations which are FDA approved and have explicit ACIP recommendations for routine use.

Intimate Partner Violence, Interpersonal and Domestic Violence, Counseling and Screening during wellness examination.

Latent Tuberculosis Infection Screening for persons at increased risk.

Lung Cancer Screening with Low-Dose CT Scan for age 55 - 80 years with at least a 30-pack per year history (with prior authorization).

Mammography Screening.

Obesity Screening and Counseling at each wellness examination. Certain patients may need medical nutrition therapy.

Osteoporosis Screening for women age 65 and older, and younger women at increased risk.

Rh Incompatibility Screening during pregnancy.

Sexually Transmitted Infections, Behavioral Counseling for adults who are sexually active or otherwise at increased risk, in a primary care setting.

Syphilis Screening for adults at increased risk.

Tobacco Cessation, Screening, Behavioral Counseling for adults who smoke, in a primary care setting (refer to pharmacy vendor for pharmacotherapy for tobacco cessation).

* These guidelines are based in part on the requirements of the Patient Protection and Affordable Care Act, and recommendations of the U.S. Preventive Services Task Force (USPSTF), U.S. Department of Health and Human Services and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. They are provided for informational purposes only, and do not constitute medical advice. Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions and may not be covered as a preventive benefit. Consult with your doctor how these guidelines may be right for you, and always consult your doctor before making any decisions about medical care. These guidelines do not necessarily reflect the vaccines, screenings or tests that will be covered by your benefit plan. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member service number on your health plan ID card.

**The ages described above are guidelines per the USPSTF. However, Delta encourages employees and covered spouses to get these screenings annually, at all ages, as part of the Delta Health Rewards program. For more information, go to [Delta.com](#) > [HR](#) > [Benefits](#) > [Delta Health Rewards](#).

Pre-Admission Testing

Pre-admission tests are performed before a hospital confinement. The tests must be related to a scheduled surgery and ordered by a physician after a condition requiring surgery has been diagnosed. The patient must be later hospitalized for the pre-admission testing to be considered Covered Services.

Private Duty Nursing

Coverage for private duty nursing is available only when **all** of the following guidelines have been met:

- Services are received on an outpatient basis
- Services are ordered by an attending physician
- Services are necessary to the treatment (rather than for the convenience of — or at the insistence of — the patient or patient's family)
- Services must be for the treatment of a non-occupational disease or injury, and must require the medical training and technical skills of a registered nurse (RN)
- Services are provided by an RN who is licensed or certified to perform the particular services needed. Services may be performed by a licensed practical nurse (LPN) under certain circumstances:
 - A recognized hospital uses a recognized agency for private duty nursing, or
 - The services of an RN are unavailable (this must be verified by the attending physician or nurse registry)
- Charges must be for nursing services only

Custodial Care is not covered. Additionally, the RN or LPN must not reside in the patient's home or be a member of the patient's immediate family.

Prosthetic Medical Appliances

The plan covers the purchase, maintenance and repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts. Artificial joints, artificial heart valves, cardiac pacemakers and intraocular lenses are examples of covered internal prosthetic appliances. Hearing aids are not covered.

The plan also covers the purchase and fitting of certain external prosthetic devices that replace or substitute a missing body part and are necessary to alleviate or correct an illness, injury or congenital defect. Artificial eyes, arms and legs, and terminal devices such as a hand or hook, are examples of external prosthetic devices covered for their initial purchase and fitting.

For covered prosthetic devices, the plan covers replacement of an initial prosthetic device only if it is needed due to normal body growth or normal wear and tear, and if it is determined to be a Covered Service by the claims administrator.

Prosthetic devices costing more than \$1,000 requires Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820**. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan.

Qualifying Clinical Trials – Routine Patient Care Costs

The Plan covers routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this coverage, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) which is not life-threatening, if UHC determines a clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip, and knees, which are not life-threatening, if UHC determines a clinical trial meets the qualifying clinical trial criteria stated below;
- Other diseases or disorders which are not life threatening, if UHC determines, a clinical trial meets the qualifying clinical trial criteria stated below.

Covered Services include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Covered Services are available only when the Plan participant is clinically eligible for participation in the qualified clinical trials as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Services for which coverage is typically provided absent a qualifying clinical trial;
- Covered Services required solely for the provision of the experimental or investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Services needed for reasonable and necessary care arising from the provision of an experimental or investigational item or service.

Routine patient care costs for qualifying clinical trials *do not* include:

- The experimental or investigational service or item. The only exceptions to this are:
 - Certain *Category B* devices;
 - Certain promising interventions for patients with terminal illnesses; and
 - Other items and services that meet specified criteria in accordance with UHC's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

A qualifying clinical trial is:

- With respect to cancer or other life-threatening diseases or conditions: A Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or the other life-threatening disease or condition and which meets any of the criteria listed in the bullets below; or
- With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening: A Phase I, Phase II, Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the criteria listed in the bullets below.
 - Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - > National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
 - > Centers for Disease Control and Prevention (CDC);
 - > Agency for Healthcare Research and Quality (AHRQ);
 - > Centers for Medicare and Medicaid Services (CMS);
 - > A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA); or
 - > A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - > The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
 - comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
 - ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
 - The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
 - The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UHC may, at any time, request documentation about the trial; or
 - The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Service and is not otherwise excluded under the Plan.

Please remember that you must receive Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** as soon as the possibility of participation in a clinical trial arises. If Delta Health Direct is not contacted to obtain Prior Authorization, you will be responsible for paying all charges and no costs of your routine patient care will be paid by the Plan.

Reconstructive Surgery

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a cosmetic procedure.

The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

You or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** before your reconstructive surgery is performed. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Second Surgical Opinion

Second surgical opinions are voluntary and are not required to obtain benefits for eligible Covered Services.

Shingles Vaccine

The Plan covers the Shingrix vaccine and the Zoster vaccine as follows:

- Beginning at age 50, the Plan covers the Shingrix vaccine at 100% (in-network) as part of Preventive Care services. For more details on covered vaccines, see "Preventive Care – Routine Physicals, Women's Preventive Services, Colonoscopies, Well Child Visits" earlier in this section.
- Beginning at age 60, the Plan covers the Zoster vaccine at 100% (in-network) as part of Preventive Care services. For more details on covered vaccines, see "Preventive Care – Routine Physicals, Women's Preventive Services, Colonoscopies, Well Child Visits" earlier in this section. If between the ages of 50 – 59, the Plan covers the Zoster vaccine as a medical service.

Skilled Nursing Facility – Convalescent/Inpatient Rehabilitation

Facility services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility are Covered Services.

- A skilled nursing facility is a nursing facility that is licensed and operated as required by law. A skilled nursing facility that is part of a hospital is considered a skilled nursing facility for purposes of the plan
- An inpatient rehabilitation facility is a hospital (or a special unit of a hospital that is designated as an inpatient rehabilitation facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law

Benefits include:

- Non-physician services and supplies received during the inpatient stay
- Room and board in a semi-private room (a room with two or more beds)

Benefits are available when a skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a skilled nursing facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.

The claims administrator will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost effective alternative to an inpatient stay in a hospital
- You will receive skilled care services that are not primarily Custodial Care

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when:

- It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient
- It is ordered by a physician
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair
- It requires clinical training in order to be delivered safely and effectively
- They are not Custodial Care
- You are expected to improve to a predictable level of recovery

Note: None of the plans pay benefits for Custodial Care or domiciliary care, even if ordered by a physician. Additionally, benefits are not available for confinements that are in connection with drug addiction, chronic brain syndrome, alcoholism, mental retardation or other mental disorders.

You or your doctor must obtain Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** before receiving skilled nursing facility services or inpatient rehabilitation facility services. For inpatient (non-Emergency) confinement, Delta Health Direct must be contacted at least five days before the scheduled admission date. If you do not receive this Prior Authorization or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by

the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Coverage will be reviewed throughout the duration for medical appropriateness.

Spine and Joint Surgery

The plan pays benefits for spine and joint surgeries that are ordered by a physician. Spine and joint surgical procedures include spine fusion surgery, spine disk surgery, total knee replacement, total hip replacement, including partial replacement, bilateral replacement and revision.

Network benefits received at a designated facility include the facility charge, physician services, implant, diagnostic testing, imaging for one CT Scan or MRI, anesthesiology, inpatient physical therapy and durable medical equipment and supplies.

Eligible services are covered at 100% (after the Deductible) of the Network Charges when using a Center of Excellence and when enrolled in the Spine and Joint Solution (SJS) Program. If using a facility that is not a Center of Excellence, eligible expenses are covered at plan level Coinsurance

Travel and lodging for the patient and one family member acting as a travel companion, up to a \$2,000 lifetime limit, is covered by the plan when a UHC Spine and Joint surgery Center of Excellence provides the treatment. You or your doctor must notify Delta Health Direct at **877-912-1820** in advance before you incur any travel and lodging expenses related to your treatment.

Surgical Charges – Inpatient/Outpatient

The plans cover charges by physicians and assistant physicians for surgical procedures. The plans also cover charges by an anesthesiologist or your physician for the administration of anesthesia in connection with a covered surgical procedure. Also covered are services by a doctor in the appropriate surgical specialty, consultation, and charges for X-rays, laboratory, exam and minor surgical procedures that are routinely performed in a doctor's office (as long as the procedure or charge is not for a cosmetic or dental surgical procedure that is excluded by the plans).

Certain surgical charges, when performed by an assistant surgeon, physician assistant, nurse practitioner or nurse specialist but billed under the surgeon's provider number, are reimbursed based on a set percentage of the surgeon's fees.

The plans also cover surgery and related services received on an outpatient basis at a hospital or alternate facility (unless the surgery and related services are not otherwise covered by the plan). Benefits include the facility charge and the charge for supplies and equipment, certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy), and physician services for radiologists, anesthesiologists and pathologists. Outpatient surgeries performed in a hospital incur a \$250 place of service surcharge (see "Place of Service Surcharge" below for details).

"Multiple surgical procedures" is defined as more than one surgical procedure being performed during the same operative session.

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In the HRA, Gold HSA, Silver HSA or Bronze HSA, covered expenses for multiple surgical procedures are limited as follows:

- The primary procedure is covered at 80% (after Deductible) if you use a Network Provider or 60% of the Eligible Expense (after Deductible) if you use a Non-Network Provider
- A secondary procedure is limited to 50% of the charge (after Deductible) that would otherwise have been considered had the procedure been performed during a separate operative session if you use Network Provider or 60% of the Eligible Expense (after Deductible) if you use a Non-Network Provider
- Another additional subsequent procedure is limited to 50% of the charge (after Deductible) that would otherwise have been considered had it been performed during a separate operative session if you use Network Provider or 60% of the Eligible Expense (after Deductible) if you use a Non-Network Provider

In the OOA HRA, OOA Gold HSA or Puerto Rico OOA, covered expenses for multiple surgical procedures are limited as follows:

- The primary procedure is covered at 80% of the Eligible Expense (after Deductible)
- A secondary procedure is limited to 50% of the Eligible Expense (after Deductible) that would otherwise have been considered had the procedure been performed during a separate operative session
- Another additional subsequent procedure is limited to 50% of the Eligible Expense (after Deductible) that would otherwise have been considered had it been performed during a separate operative session

In the Retiree & Survivor Bronze OOA HSA, covered expenses for multiple surgical procedures are limited as follows:

- The primary procedure is covered at 70% of the Eligible Expense (after Deductible)
- A secondary procedure is limited to 50% of the Eligible Expense (after Deductible) that would otherwise have been considered had the procedure been performed during a separate operative session
- Another additional subsequent procedure is limited to 50% of the Eligible Expense (after Deductible) that would otherwise have been considered had it been performed during a separate operative session

Prior Authorization is required for all inpatient surgeries and the following outpatient surgeries: arthroscopy, hysterectomy, sinuplasty, cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implants, sleep apnea surgeries, orthognathic surgeries, and for selected infusions of anti-inflammatory/immune modulator medications covered under the medical benefit when administered in an outpatient hospital setting. If you do not receive this Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Place of Service Surcharge

The HRA, Gold HSA, Silver HSA, Bronze HSA and Retiree & Survivor Bronze HSA Medical Options include a \$250 "place of service surcharge" that applies to outpatient surgeries that are performed in a hospital. This surcharge may be avoided by making sure that the facility where these outpatient services are received is independently run, not managed, billed or otherwise associated with a hospital.

This \$250 place of service surcharge applies to Network and Non-Network Services and must be paid in addition to the annual Deductible and Coinsurance amount. However, place of service surcharges that you pay count towards the Annual Out-of-Pocket Maximum and will not apply once the Annual Out-of-Pocket Maximum is reached.

For assistance in locating a free-standing facility, please contact Delta Health Direct at **877-912-1820**.

Temporomandibular Joint Dysfunction (TMJ)

The plan covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint, when provided by or under the direction of a physician. Coverage includes treatment required as a result of accident, trauma, a congenial anomaly, developmental defect or pathology.

Therapeutic Treatments - Outpatient

The plan covers therapeutic treatments received on an outpatient basis at a hospital or alternate facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology. Coverage also includes medical education services that are provided on an outpatient basis at a hospital or alternate facility by appropriately licensed or registered healthcare professionals.

Prior Authorization is required for all outpatient therapeutics (except for dialysis). If you do not receive this Prior Authorization from UHC by calling Delta Health Direct at **877-912-1820** or if the service is not authorized, you will be responsible for paying all charges and no benefits will be paid by the Plan. Additionally, if some of the services being requested are not approved, the applicable expenses will be denied.

Therapy — Physical, Occupational, Speech Rehabilitation

Rehabilitative physical, occupational and speech therapy are covered only under very specific circumstances. For physical and occupational therapy, the therapy must be for the purpose of training the patient to perform the activities of daily living. Benefits are available only for therapy that is expected to result in significant physical improvement in your condition.

Rehabilitation services must be performed by a physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a physician's office or on an outpatient basis at a hospital or alternate facility.

Additionally, if physical or occupational therapy is required when bodily function is lost or impaired as a result of disease or accidental injury, all of the following requirements must be met:

- A specific occupational or physical therapy treatment program, which details the type, frequency and expected duration of the therapy to be administered, is prescribed by a covered physician
- The services of the occupational or physical therapist are rendered while the patient remains under the care of a covered physician
- There is a reasonable expectation that the prescribed occupational or physical therapy will result in significant improvement of bodily function
- There is a periodic reevaluation of the treatment program to confirm that a significant improvement in bodily function has occurred and is expected to continue, and that the services of the therapist are still being provided in accordance with specific orders from the attending physician

Massage therapy is not a covered benefit.

Speech therapy is covered for adults and children only when the speech impediment or speech dysfunction results from injury, sickness, stroke, cancer, autism spectrum disorders or congenital anomaly, or is required following the placement of a cochlear implant. Benefits are available only for the rehabilitation services that are expected to result in significant improvement in the patient's condition within two months of the start of treatment. Services must be performed by a licensed therapy provider under the direction of a physician. Speech therapy for learning disabilities and developmental delays is not a Covered Service.

Coverage is limited to 30 combined network and non-network visits per calendar year per type of therapy. After the limit has been met, additional visits are subject to medical review. You or your doctor should notify UHC of your request for additional therapy visits by calling Delta Health Direct at **877-912-1820**.

Transgender Services

The plan covers the treatment of gender dysphoria (as defined below) for covered participants who are at least 18 years old. The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance. Coverage is limited to the following services ordered by a physician:

- Psychotherapy and associated co-morbid psychiatric diagnoses
- Cross-sex hormone therapy
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy
- Genital surgery and bilateral mastectomy or breast reduction surgery that meets the following requirements:
 - For breast surgery, the participant must provide documentation of a written psychological assessment from at least one qualified behavioral health provider experienced in treating gender dysphoria. The assessment must document that the covered person meets all of the following criteria:
 - > Persistent, well-documented gender dysphoria
 - > Capacity to make a fully informed decision and to consent for treatment
 - > Must be 18 years or older
 - > If significant medical or mental health concerns are present, they must be reasonably well controlled
 - For genital surgery, the participant must provide documentation of a written psychological assessment from at least two qualified behavioral health providers experienced in treating gender dysphoria, who have independently assessed the covered person. The assessments must document that the covered person meets all of the following criteria:
 - > Persistent, well-documented gender dysphoria
 - > Capacity to make a fully informed decision and to consent for treatment
 - > Must be 18 years or older
 - > If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - > Complete at least 12 months of successful, continuous full-time, real-life experience in the desired gender
 - > Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated)

Gender dysphoria is a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Diagnostic criteria for gender dysphoria in adults include a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning

Tubal Ligation

Tubal ligation is covered when it is performed in an outpatient surgical facility or an inpatient surgical facility. Surgical reversal of this procedure is not covered.

Upper Lid Blepharoplasty

This corrective eyelid surgery is covered. However, this is not covered if done as a cosmetic procedure.

Vasectomy

Vasectomy is covered when performed in a physician's office. Surgical reversal of this procedure is not covered.

Vein Treatment

Vein stripping, ligation and sclerotherapy are covered when considered a Covered Service and not cosmetic in nature. Note that in most cases, 6-8 weeks of compression hose therapy under the supervision of the physician is required prior to treatment.

Virtual Visits

The plans cover virtual visits including the diagnosis and treatment of low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **myuhc.com** or by calling the telephone number on your ID card.

Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by an in-person physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities.

Well Child Examinations

Refer to "Preventive Care."

Wigs

Wigs are covered when purchased as a result of burns, chemotherapy, radiation therapy, and alopecia areata and totalis, subject to a maximum benefit of \$500 per episode. Replacement costs for wigs are covered up to \$500 only if needed due to normal body growth or normal wear and tear, and if determined to be a Covered Service by the claims administrator.

X-Rays – Diagnostic

Covered X-ray and diagnostic procedures may include, electrocardiogram, electroencephalogram, mammogram, radiation therapy and ultrasound. To be considered Covered Services, X-rays and diagnostic procedures can be performed in your physician's office or at another healthcare facility, such as a hospital or imaging center.

What the Delta Medical Plans Do Not Cover

The Delta medical options do not cover the following:

- Services and supplies that do not meet the definition of a Covered Service
- Services rendered that were not recommended and approved by the attending physician
- Expenses not resulting from direct treatment of a specific accidental bodily injury, illness or disease
- Amounts greater than the Eligible Expense
- Claims for charges that are more than one year old or more than two years old for the Puerto Rico OOA Medical Option
- Expenses for services rendered by a family member or for which the patient is not required to pay, or charges that would not have been made in the absence of coverage
- Charges made by a hospital owned by or performing services for the U.S. government if the charges are directly related to a sickness or injury connected to military service
- Services, supplies or other care for injury or illness for which there is non-group insurance (except individual health insurance policies) providing medical payments or medical expense coverage, such as automobile no fault or medical payment insurance, regardless of whether the other coverage is primary, excess or contingent to this certificate. If benefits subject to this provision are paid or provided by Delta Air Lines, Inc., or a Delta Plan, Delta and the plan reserve all rights to recover the reasonable value of such benefits as provided in the "Coordination of Benefits; Subrogation and Right of Recovery Terms" section of this handbook
- Services or supplies determined not to be Medically Necessary by UHC
- Services or supplies that require Prior Authorization but are not preauthorized or approved during the Prior Authorization process

In addition, the medical options do not cover the following services, treatments, supplies and items (listed in alphabetical order) even if they are recommended by a physician and they are the only available treatment for your condition. The services, treatments, items or supplies listed in this section are not Covered Services (except as may specifically be provided for in this handbook), including:

- Abortions that are non-therapeutic (including drug-induced pregnancy termination)
- Abdominoplasty
- Alternative treatments including aromatherapy, hypnotism, rolfing and other forms of alternative treatments as defined by the Office of Alternative Medicine of the National Institutes of Health
- Amniocentesis, ultrasound or any other procedures requested solely for sex determination of a fetus, unless necessary to determine the existence of a sex-linked genetic disorder
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Bariatric surgery (including surgeon and assistant surgeon fees) that is not performed at a Bariatric Center of Excellence
- Behavioral health treatment that may be mandated by court-ordered Custodial Care when there is no expectation the treatment will alter the condition or diagnostic assessments of children with learning disabilities/problems
- Blepharoplasty, except if it is for vision correction

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- Boarding schools, including those providing a therapeutic environment
- Body contouring, such as lipoplasty
- Breast enlargement, including augmentation mammoplasty and breast implants
- Breast implant replacements if the earlier breast implant was performed as a cosmetic procedure (however, replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a mastectomy)
- Brow lift
- Calf implants
- Cancer treatment: Any facility or physician providing services through Cancer Treatment Centers of America
- Cheek implants
- Chelation therapy, except to treat heavy metal poisoning
- Chin implants
- Chiropractic Care performed by a Non-Network Provider, if enrolled in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA
- Christian Science practitioners
- Colonic lavage/irrigation
- Compression hose
- Cosmetic procedures and surgery. Procedures that correct a congenital anomaly (a physical developmental defect that is present at birth, and is identified within the first 12 months of birth) without improving or restoring physiologic function are considered cosmetic procedures. The fact that psychological consequences or socially avoidant behavior results from an injury, sickness or congenital abnormality does not classify a surgery or procedure done to relieve such consequences or behavior as a reconstructive procedure
- Custodial services not intended primarily to treat a specific injury or sickness. Additional custodial services not covered are:
 - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment
 - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered healthcare professional
 - Education or training
 - Domiciliary care, respite care and rest cures
 - Private duty nursing (except as described under Covered Services)
- Dental care (except as identified under "Dental Services Covered by this Plan: Accident or Medical Condition Related", "Orthognathic Surgery" and "Temporomandibular Joint Dysfunction (TMJ)"), including:
 - Endodontics, periodontal surgery and restorative treatment
 - Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) when the services are considered dental in nature
 - Preventive dental care

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- Diagnosis or treatment of teeth, jawbones or gums. Examples include extractions (including wisdom teeth), restoration and replacement of teeth, medical or surgical treatments of dental conditions, or services to improve dental clinical outcomes
- Dental implants bone grafts and other implant-related procedures
- Braces and other orthodontic treatments
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, except as identified under “Dental Services Covered by this Plan: Accident or Medical Condition Related” and “Hospital Care — Inpatient and Outpatient Services”
- Treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly such as cleft lip or cleft palate
- Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
- Drugs: Prescription and non-prescription drugs, except as provided under OptumRx™, a UnitedHealth Group Company
- Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, a nursing home or an assisted living facility
- Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), as well as oral vitamins and oral minerals, except when the sole source of nutrition. Infant formula that is taken orally, or purchased over the counter, or that does not require a prescription is always excluded.
- Exercise equipment (use, rental or purchase) or health club/spa membership fees
- Experimental or investigational services and unproven services and all services related to experimental or investigational and unproven services are excluded. The fact that an experimental or investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.
 - **Unproven Services** – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
 - > Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
 - > Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The claims administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the claims administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care

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services. These medical and drug policies are subject to change without prior notice. You can view these policies at **myuhc.com**.

Please note: If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), the claims administrator may, at their discretion, consider an otherwise unproven service to be a Covered Service for that sickness or condition. Prior to such a consideration, the claims administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition. The decision about whether such a service can be deemed a Covered Service is solely at the claims administrator's discretion. Other apparently similar promising but unproven services may not qualify.

- Eyeglasses, contact lenses and eye refractions unless required due to accidental injury or cataract surgery. Replacements of contact lenses that are lost, damaged or required solely due to refractive changes are not covered. Charges for extra lenses are not covered. Charges for replacement lenses are covered when the existing lenses wear out and cannot be repaired, or when they are required because of a change in the patient's physical condition (not including refractive changes). Surgical treatment for correction of refractive errors, including radial keratotomy and LASIK surgery, are not covered. Contact lenses or scleral shells that are used to treat an injury or disease (e.g., corneal abrasion or keratoconus) may be covered as a therapeutic service.
- FAA flight physicals are not covered by the DABHP or other medical options. Delta pilots should contact the Chief Pilots Support Center at **404-715-1323** or at **877-DAL-2FLY** for information regarding reimbursement
- Face lift
- Facial bone remodeling for facial feminizations
- Fee forgiveness: No benefits are provided for health services for which any Copayments, Deductibles or fees are waived
- Foot care except when needed for severe systemic disease. The following are not covered: Routine foot care (including the cutting or removal of corns and calluses, and nail trimming, cutting or debriding), hygienic and preventive foot care (cleaning and soaking of the feet, applying skin creams to maintain skin tone, other services that are performed when there is not a localized illness, injury or symptom involving the foot), treatment of flat feet and treatment of subluxation of the foot
- Forehead lift
- Hair removal
- Hair transplantation
- Hearing aids or examinations
- Herbal medicine, holistic or homeopathic care, including drugs
- Holistic medicine
- Hormone pellet implantation that is not FDA approved
- Infertility: Artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), cloning, micro-injection, any other assisted reproductive technologies, and any processes or charges associated with these procedures. Injectable or oral infertility drug treatments are also not covered

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- Injection of fillers or neurotoxins
- Inpatient private duty nursing
- Kidney Resource Services (KRS) not approved or authorized by the KRS Program
- Laser eye surgery and all associated services and supplies
- Lip augmentation
- Lip reduction
- Liposuction
- Massage therapy
- Mastopexy
- Membership costs for health clubs, weight loss clinics and similar programs
- Neck tightening
- Nose implants
- Occupational injury/disease: Expenses related to/arising from an occupational injury/disease
- Organ transplant services, including travel and lodging expenses, if treatment is not received at a UnitedHealthcare URN organ transplant facility
- Orthotics: Charges for orthotics, custom molded shoes, orthopedic shoes or prefabricated shoes designed with special characteristics such as inserts, lifts or wedges, except as specified previously under "Podiatry Care"
- Pectoral implants for chest masculinization
- Personal or comfort items in the hospital, such as personal care kits, television and telephone rental
- Physical conditioning and fitness programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation, including facility charges and exercise equipment
- Preventive services not performed by a Network Provider, if enrolled in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA
- Private hospital rooms (except as described previously under Hospital Care — Inpatient and Outpatient Services)
- Prostheses, certain internal or external prostheses, except as specified previously under "Durable Medical Equipment" or "Prosthetic Medical Appliances"
- Radial keratotomy and all associated services and supplies
- Reports, evaluations, examinations or hospitalizations not required for health reasons, such as employment or insurance examinations
- Reduction thyroid chondroplasty
- Reversal of voluntary sterilization procedures
- Rhinoplasty
- Sensitivity training, educational training therapy or treatment for an education requirement

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- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a participant under this plan and is undergoing a covered transplant
- Services given by a pastoral counselor
- Skin resurfacing
- Supplies not considered durable medical equipment, such as humidifiers, dehumidifiers, air purifiers, heating pads, etc.
- Teeth: Treatment of the teeth or periodontium, except for charges associated with accidental injury or certain oral surgeries as described in this "Medical Benefits" section
- Telephone consultations, except as part of telephonic Employee Assistance Program (EAP)
- Temporomandibular joint dysfunction (TMJ): Services for the evaluation and treatment of TMJ, when the services are considered dental in nature, including oral appliances
- Therapy to improve general physical condition — including massage therapy
- Thyroid cartilage reduction
- Trachea shave
- Travel or lodging expenses
 - For bariatric surgery, above the \$10,000 lifetime limit or if treatment is not received at a UnitedHealthcare bariatric Center of Excellence
 - For cancer treatment, above the \$10,000 lifetime limit or if treatment is not received at a UnitedHealthcare URN Cancer Resource Services (CRS) Facility
 - For organ transplant services, above the \$10,000 lifetime limit or if treatment is not received at a UnitedHealthcare URN organ transplant facility
 - For spine and joint services, above the \$2,000 lifetime limit or if treatment is not received at a UnitedHealthcare Spine and Joint Center of Excellence
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Vision exam/vision screening
- Voice lessons
- Voice modification surgery
- Voice therapy
- Weight-loss products, treatments or programs including food supplements for weight loss and personal trainers

The exclusions listed below apply to Behavioral Health and Substance Use Disorder Treatment and Neurobiological Disorders - Autism Spectrum Disorder Services:

- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Transitional living services
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act

Other expenses not listed may or may not be covered under UHC guidelines. Contact Delta Health Direct at **877-912-1820** if you have questions about Covered Services.

What the Pharmacy Benefit Does Not Cover

No benefits are paid when a prescription is purchased at a non-network retail pharmacy or not filled via the UHC mail order program.

The following list of drugs, items and expenses not covered by the plans and may be modified or added to at any time.

The prescription drug benefit does not cover the following (even if they are prescribed by a doctor):

- Any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician's order
- More than a 90-day supply when dispensed in any one prescription order filled through a participating mail order pharmacy
- Medication that is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution that operates, or allows to be operated, on its premises a facility for dispensing pharmaceuticals
- Prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation law or any public program other than Medicaid
- Expenses incurred to the extent that payment for them is unlawful where the person resides when the expenses are incurred

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- Charges that the person is not legally required to pay
- Charges that would not have been made if the person were not covered by these benefits
- Charges for prescription drugs that are greater than the Eligible Expense as determined by OptumRx™ (for the Puerto Rico OOA Medical Option)

In addition to other items not covered in accordance with UnitedHealthcare Pharmacy Management guidelines, the following are not covered under the plan:

- Anabolic steroids
- Cosmetic drugs: Drugs used for cosmetic purposes, including, but not limited to, topical minoxidil (Rogaine) and tretinoin (Renova). Retin-A is not covered when prescribed for a covered individual past the age of 29 without Prior Authorization from UHC
- Compounded drugs that contain a non-FDA-approved bulk chemical which includes "mix-at-home" compounding kits
- Experimental drugs or drugs labeled "Caution — limited by federal law to investigational use"
- Immunization agents, biological serum, blood or blood plasma (Note: Blood and blood plasma are covered under the medical portion of the plans)
- Member-pays-the-difference" amounts if enrolled in an HRA or HSA Medical Option and you or your physician choose to receive a brand name drug when a chemically equivalent generic is available. This amount equals 100% of the difference in the cost of the two drugs. Note that member-pays-the-difference amounts you pay are counted toward the annual Pharmacy Out-of-Pocket Maximum for the HRA Medical Options or the annual Out-of-Pocket Maximum for the HSA Medical. It also applies to the Deductible for non-preventive prescription drugs if you are enrolled in an HSA Medical Option
- Multiple package products that generally include one FDA-approved product and another product like bandages for example, and the individual ingredients are not FDA-approved to be used in combination
- Non-FDA approved drugs
- Non-legend (non-prescription) drugs, except insulin
- Non-preventive brand name drugs
- Nutritional or dietary supplements, anti-obesity drugs or anorexiant (Note: Nutritional/dietary supplements are covered under the medical portion of the plans if they are the only form of sustenance)
- Over-the-counter medications, except prenatal vitamins that do not require a prescription order or refill by federal or state law before being dispensed, FDA-approved contraceptives prescribed by a health care provider, such as contraceptive sponges or spermicides, and any drug that is therapeutically equivalent to an over-the-counter drug. Contact Delta Health Direct for more information about drugs that are therapeutically equivalent to over-the-counter medications
- Prescription drugs not listed on the Prescription Drug List (PDL)
- Prescription drugs that do not receive prior authorization or are not approved
- Brand Name Preventive Drugs after the participant reaches his or her annual Deductible or Annual Coinsurance Maximum
- Tobacco cessation products, including nicotine gum and patches, except when covered as a part of participation in the Delta Health Direct Quit for Life program

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- Tier 4 prescription drugs, though you can receive a discounted price on these drugs if purchased at a network pharmacy. The costs you pay for drugs in Tier 4 do not apply to the annual Pharmacy Out-of-Pocket Maximum under the HRA Medical Options or the annual Deductible and Annual Coinsurance Maximum under the HSA Medical Options
- Therapeutic devices or appliances, support garments and other non-medicinal substances
- Progesterone suppositories
- Appetite suppressants and other weight-loss products
- General and injectable vitamins (This exclusion does not apply to prenatal vitamins, vitamins with fluoride, and B-12 injections that are covered)
- Medication or health services associated with the use of non-surgical or drug-induced pregnancy termination
- Growth hormones when used to treat idiopathic short stature

The law of the jurisdiction where you live when a claim occurs may prohibit some benefits. If so, those benefits cannot be paid.

HEALTH MAINTENANCE ORGANIZATIONS (HMO)

Health maintenance organizations (HMOs) provide comprehensive healthcare with an emphasis on Preventive Care.

Eligibility for Health Plan Hawaii and Humana Health Plan of Puerto Rico

If you are based in Hawaii and/or live within the Health Plan Hawaii service area or live within the Humana Health Plan of Puerto Rico service area, and otherwise meet the eligibility requirements for the medical plans (see the "Eligibility" section of this handbook), you are eligible to enroll in the Health Plan Hawaii HMO or Humana Health Plan of Puerto Rico, respectively. For Hawaii residents and those employees based in Hawaii, Health Plan Hawaii is the state approved "pre-paid" medical plan (see below for more information).

In addition to enrolling through Delta, Health Plan Hawaii or Humana Health Plan of Puerto Rico require *new members* to complete a member application form. You must contact the HMO's Member Services department to get the form. When you complete the form, you must indicate the same dependents that you elected to cover for your Delta benefits. Make a copy of the completed form for your records and return the form to the HMO. **Remember that you must enroll through Delta as well as through Health Plan Hawaii or Humana Health Plan of Puerto Rico.** If you submit an application to the HMO but fail to enroll in the HMO through Delta, that HMO application is not valid.

When you choose HMO coverage during the annual open enrollment period, your coverage remains in effect for the following calendar year unless:

- You move out of the HMO service area
- You are a member of an HMO that ceases operation or ceases to be offered
- You fail to meet eligibility requirements for Delta medical coverage
- You fail to pay required contributions to continue coverage
- Other reasons for ineligibility as set forth in the "Eligibility" section of this handbook apply

Hawaii Prepaid Health Care Act

The 1974 Hawaii Prepaid Health Care Act set minimum standards on health care coverage for workers in Hawaii. The law requires employers (such as Delta) to provide health care coverage for eligible employees who work in Hawaii. Employees who are NOT subject to a collective bargaining agreement and meet other requirements are considered to be eligible.

How an HMO Works

With an HMO, a set of doctors and other providers offer a total managed healthcare program. Read on to learn how to use an HMO.

HMO Providers

As a participant, you must receive care from a provider within your HMO. No benefits are payable if you receive non-Emergency care from a non-HMO provider. If you use healthcare providers that are not affiliated with the HMO, you are responsible for paying the entire cost unless the treatment is approved by the HMO.

Typically, you must coordinate your healthcare through a Primary Care Physician (PCP), and obtain referrals to see specialists.

Also, if you cover an eligible family member who lives outside the HMO service area, or if you live in another location for part of the year, you or your covered family member must return to the service area for treatment through the HMO's doctors or facilities.

Emergency Care

While there is generally no coverage for care received outside the HMO, there is coverage for Emergency or urgent care. You should know how your HMO covers Emergency and urgent care both inside and outside the HMO's service area. Contact your HMO for specific coverage information.

Oral Surgery

Some oral surgery procedures may be considered medical expenses rather than dental expenses. Contact your HMO's Member Services for detailed coverage information. Understand that because some HMOs consider oral surgeries dental expenses while the Delta plans consider them medical expenses, in some cases, this could leave you with no coverage for those expenses.

Prescription Drug and Behavioral Health Coverage

As an HMO member, you receive all prescription drugs and behavioral healthcare coverage through your HMO (not through UnitedHealthcare Pharmacy Management or OptumHealth Behavioral Solutions). Contact your HMO for specific information about coverage for prescription drugs and mental healthcare.

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Health Plan Hawaii Overview

Delta has neither control over nor responsibility for the quality of HMO services rendered to members, for failure to deliver such services, for HMO providers, or for any disputes that may arise between members and their HMO. All HMO service-related complaints and appeals of denied benefit claims must be filed directly with the HMO, not Delta. Delta has neither input nor responsibility for any benefits denied by an HMO. By providing this information, Delta is not endorsing any HMO product.

2019 HEALTH PLAN HAWAII PLUS (ZB)	
Plan Provisions	In-Network
Annual Deductible	\$350 individual/\$1,050 family
Annual Out-of-Pocket Limit	\$3,000 individual/\$9,000 family (medical plan coverage) \$3,600 individual/\$4,200 family (prescription drug coverage)
YOUR COST	
IF YOU VISIT A HEALTH CARE PROVIDER'S OFFICE OR CLINIC	
Primary Care or Specialist Visit	\$15 copay/visit
Preventative Care (Well Child Care Physician Visit)	No charge
Screening (Grade A & B recommendations of the U.S. Preventive Service Task Force)	No charge
Immunization (Standard and Travel)	No charge
IF YOU HAVE A TEST	
Diagnostic Test	20% (inpatient and outpatient)
X-Ray	20% (inpatient and outpatient)
Blood Work	20% (inpatient and outpatient)
Imaging (CT/PET scans, MRI)	20% (inpatient and outpatient)
IF YOU HAVE OUTPATIENT SURGERY	
Facility Fee (e.g., ambulatory surgery center)	No charge
Physician Visit	\$15 copay/visit
Surgeon Fees	\$15 copay (cutting or non-cutting)
IF YOU NEED IMMEDIATE MEDICAL ATTENTION	
Emergency Room Services – Physician Visit	No charge
Emergency Room Services – Emergency Room	\$75 copay/visit
Emergency Medical Transportation (air or ground)	20% co-insurance
Urgent Care	\$15 copay/visit

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2019 HEALTH PLAN HAWAII PLUS (ZB)	
Plan Provisions	In-Network
YOUR COST	
IF YOU HAVE A HOSPITAL STAY	
Facility Fee (e.g., hospital room)	20% co-insurance
Physician Visit	\$15 copay/visit
Surgeon Fee	No charge
IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE ABUSE NEEDS	
Mental/Behavioral Health – Physician Services	No charge (inpatient) \$15 copay/visit (outpatient)
Mental/Behavioral Health – Hospital and Facility Services	20% co-insurance (inpatient) No charge (outpatient)
Substance Use Disorder – Physician Services	No charge (inpatient) \$15 copay/visit (outpatient)
Substance Use Disorder – Hospital and Facility Services	20% co-insurance (inpatient) No charge (outpatient)
IF YOU ARE PREGNANT	
Prenatal and Postnatal Care	No charge
Delivery (surgery)	No charge
Inpatient Services (Hospital Room and Board)	20% co-insurance
IF YOU NEED HELP RECOVERING OR HAVE OTHER HEALTH NEEDS	
Home Health Care	No charge
Rehabilitation Services	\$15 copay/visit
Habilitation Services	Not covered
Skilled Nursing Care	20% co-insurance
Durable Medical Equipment	50% co-insurance
Hospice Service	No charge
IF YOUR CHILD NEEDS DENTAL OR EYE CARE	
Eye Exam (one exam per calendar year)	\$15 copay/exam
Glasses	Not covered
Dental Check-Up	Not covered
ONLINE CARE: As an HMSA member, you and your covered dependents may access HMSA's Online Care through www.hmsa.com	
WELL-BEING CONNECT: As an HMSA member, you and your covered dependents age 18 and older are entitled to Well-Being Connect, an online health portal that includes a well-being assessment that evaluates your health and lifestyle at no cost. The assessment helps you design a personal wellbeing plan that fosters healthy behavior.	

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2019 HEALTH PLAN HAWAII PLUS Prescription Drug Benefits		
PRESCRIPTION DRUGS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Tier 1: Mostly Generic Drugs	\$7 copay/prescription	\$7 copay and 20% co-insurance/prescription
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three copays for 61-90 day supply.	
Tier 2: Mostly Preferred Drugs	\$30 copay/prescription	\$30 copay and 20% co-insurance/prescription
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three copays for 61-90 day supply.	
Tier 3: Mostly Other Brand Name Drugs	\$30 copay/prescription plus \$45 Other Brand Name Cost Share	\$30 copay and 20% co-insurance/prescription plus \$45 Other Brand Name Cost Share
	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three copays for 61-90 day supply.	
Tier 4: Mostly Preferred Specialty Drugs	\$100 copay/prescription	Not covered
	Retail benefit limited to a 30-day supply.	
Tier 5: Mostly Other Brand Name Specialty Drugs	\$200 copay/prescription	Not covered
	Retail benefit limited to a 30-day supply.	
MAIL SERVICE PRESCRIPTION PROGRAM (FROM AN HMSA CONTRACTED PROVIDER)	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Tier 1: Mostly Generic Drugs	\$11 copay/prescription	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
Tier 2: Mostly Preferred Drugs	\$65 copay/prescription	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
Tier 3: Mostly Other Brand Name Drugs	\$65 copay/prescription plus \$135 ¹ Other Brand Name Cost Share	Not covered
	One mail order copay for 84-90 day supply at a 90 day at retail network or contracted mail order provider.	
Tier 4: Mostly Preferred Specialty Drugs	Not covered	Not covered
Tier 5: Mostly Other Brand Name Specialty Drugs	Not covered	Not covered
<p>NOTE: When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you will be responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you chose not to use the generic equivalent or the particular generic equivalent was not available at the pharmacy.</p>		

¹ \$45 retail Other Brand Name cost share times three-month supply.

2019 HEALTH PLAN HAWAII PLUS IMPORTANT INFORMATION

All copayments shown are based on eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered.

Please Note: Eligible charge does not include excise tax or other tax. You are responsible for all taxes related to the medical care you receive.

For Health Plan Hawaii and Health Plan Hawaii Plus, HMSA requires the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as their PCP.

Women do not need prior authorization from HMSA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in their health center who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Services from a non-network provider are not covered with the exception of emergency care and/or referrals from your in-network PCP.

For information on how to select a PCP or a list of participating health care providers, visit hmsa.com/search/providers. If you require a hard copy listing, please visit an HMSA officer nearest you or call HMSA Customer Service at **948-6372** on Oahu or toll-free at **1-800-776-4672**.

HEALTHCARE BENEFITS HANDBOOK

Humana Health Plan of Puerto Rico Overview

Delta has neither control over nor responsibility for the quality of HMO services rendered to members, for failure to deliver such services, for HMO providers, or for any disputes that may arise between members and their HMO. All HMO service-related complaints and appeals of denied benefit claims must be filed directly with the HMO, not Delta. Delta has neither input nor responsibility for any benefits denied by an HMO. By providing this information, Delta is not endorsing any HMO product.

2019 Humana Health Plan of Puerto Rico	
Benefits/Features	Network Coverage
PROFILE	
Member Services	(787) 282-7900 ext. 5500 Monday–Friday: 6:00 a.m. – 6:00 p.m.; Saturday: 7:00 a.m. – 4:00 p.m.; Sunday: 11:00 a.m. – 4:00 p.m.; Plaza Las Americas Monday-Saturday: 9:00 a.m. – 6:00 p.m. Sunday: 9:00 a.m. – 4:00 p.m.
Health Plan Website	www.humana.com
Is a Member Application Required If You Are a New Member?	Yes
HEALTHCARE BENEFITS	
PCP/Specialist Office Visit	\$5 Copay
Pre- and Post-Natal Visits	\$5 Copay
Routine Physical Exam	Covered at 100% with Network Providers
Well Child Exams	Covered at 100% with Network Providers
Ob/Gyn Exams and Mammograms	Exams: Covered at 100% with Network Providers Mammograms: Covered at 100% with Network Providers
Outpatient X-Ray and Lab	Covered at 100%
Outpatient Surgery	Covered at 100%
Emergency Room	Covered at 100% for accident; \$20 Copay for illness
Emergency Medical Transportation	\$0 copay/ trip between facilities \$25 copay/ ground trip
Urgent Care Centers	Covered at 100% for accident; \$20 Copay for illness
Inpatient Semi-Private Room and Board	Covered at 100%
Inpatient Surgery	Covered at 100%
Delivery and Newborn Charges	Covered at 100%

HEALTHCARE BENEFITS HANDBOOK

2019 Humana Health Plan of Puerto Rico	
Benefits/Features	Network Coverage
Mental Health Inpatient Treatment	Covered at 100%
Mental Health Outpatient Treatment	\$5 Copay per visit
Substance Use Disorder Inpatient Treatment	Covered at 100%
Substance Use Disorder Outpatient Treatment	\$5 Copay per visit
Chiropractic Care	\$5 Copay per visit, up to 15 visits per year
Durable Medical Equipment	Covered at 50%
PRESCRIPTION DRUGS	
Formulary	F50 (RX2)
Retail Generic	\$2.50 Copay per prescription for up to a 30-day supply
Retail Brand	\$5 Copay per prescription for up to a 30-day supply
Mail Order Generic	\$10 Copay per prescription for up to a 90-day supply of maintenance drugs only
Mail Order Brand	\$10 Copay per prescription for up to a 90-day supply of maintenance drugs only

FLEXIBLE SPENDING ACCOUNTS

FLEXIBLE SPENDING ACCOUNTS

Healthcare and Dependent Care Flexible Spending Accounts (FSAs) are offered as part of Delta's benefits program, and are administered by UnitedHealthcare (UHC). These accounts allow you to set aside money on a pre-tax basis to pay for eligible healthcare and dependent care expenses not covered or reimbursed by another benefit plan or account. Your decision to participate in either or both of these voluntary accounts should be based on your needs and personal situation. It is important that you understand the advantages and limitations of FSAs before you decide whether to participate.

Be sure to read this section carefully before enrolling in an FSA. The Internal Revenue Service (IRS) and the Tax Code place restrictions on these plans that can result in the forfeiture of your contributions under certain conditions.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

Who Is Eligible

Generally, to make pre-tax contributions to an FSA, you must be eligible for Delta healthcare benefits (though you do not have to be covered by a Delta medical plan to participate in the FSAs) and receiving active pay.

If you are enrolled in coverage and start receiving benefits from the Delta Disability and Survivorship Plan, special rules apply to your FSA eligibility:

- Ground, flight dispatcher and flight attendant employees: If you are receiving paid maternity leave, certified time or 66.67% OJI pay, your pre-tax contributions to your Healthcare FSA will automatically continue through the end of the calendar year while receiving this type of pay. If you are receiving short-term disability (STD) benefits or long-term disability (LTD) benefits, your Healthcare FSA contributions are automatically taken from your STD or LTD pay through the end of the calendar year on a post-tax basis. Your contributions to the Dependent Care FSA automatically stop when you go on any inactive status. See the *Disability Benefits Handbook* for more information on paid maternity leave, certified time, 66.67% OJI pay or disability benefits
- Pilots: If you are making pre-tax payroll deductions to the Healthcare FSA and/or the Dependent Care FSA at the time you start receiving disability or paid maternity leave benefits from the Delta Pilots Disability and Survivorship Plan during the year, your pre-tax contributions to your Healthcare FSA and/or Dependent Care FSA will be deducted from your disability or maternity leave pay

For more information, please see the "Eligibility" section of this handbook — under the "Eligible Participants" heading, look for section called "Disabled Employees"

For all other inactive statuses, you may continue participation in the Healthcare FSA on an after-tax basis either through COBRA or Direct Bill. For details on COBRA, see the "COBRA Continuation Coverage" section of this handbook.

Attention: Retirees, Survivors and Those Eligible for the Puerto Rico Out-of-Area Medical Option and Humana Health Plan of Puerto Rico

Retirees, survivors and those eligible for the Puerto Rico Out-of-Area (OOA) Medical Option and Humana Health Plan of Puerto Rico are not eligible to enroll in and make contributions to either a Healthcare or a Dependent Care Flexible Spending Account.

Dependent Expenses

The medical and/or dependent care expenses of your eligible tax dependents may be submitted for reimbursement if you participate in the FSAs. For more details concerning eligible dependent expenses, see the information under the "Your Dependents" headings that appears later in this section.

How FSAs Work

FSAs are reimbursement accounts that enable you to reduce your taxable income while budgeting for anticipated healthcare and dependent care expenses.

FSAs enable you to set aside pre-tax dollars to pay for Eligible Expenses. You decide how much money you want to put into an FSA, and that money is deducted from your paycheck in equal installments during the year before Social Security and federal taxes (and, in some cases, state and local taxes) are taken out. This reduces your take-home pay and your taxes. You then use your FSA to reimburse yourself for eligible healthcare or dependent care expenses.

This reimbursement process is similar to the way you file medical claims. After you incur an Eligible Expense, you receive some or all of the dollars you have set aside, depending on the amount of your expenses and whether the reimbursement is a healthcare or dependent care expense. The reimbursements you receive are tax-free.

The IRS allows you tax advantages when you contribute to an FSA on a pre-tax basis. Therefore, the money you contribute during a given year can only be used to pay Eligible Expenses for a specified time period. Because you can run into problems if you have money left in your account at the end of the plan year, be sure you read "Filing for Reimbursement" and "The 'Use It or Lose It' Rule" later in this "Flexible Spending Accounts" section of the handbook.

Types of FSAs

Delta offers you the opportunity to enroll in two types of FSAs — one for eligible healthcare expenses (the Healthcare FSA) and one for eligible day care expenses (the Dependent Care FSA). Both types of FSAs are administered by UHC.

These are two separate types of accounts for two distinct purposes. The funds in one account may not be used to cover expenses in the other account. You may participate in either of these accounts, both or neither — depending on your needs and whether you have Eligible Expenses.

There are two kinds of Healthcare FSAs:

- Full Purpose, which you can elect if you enroll in the HRA, OOA HRA or "No Coverage", and
- Limited Purpose, which is the only Healthcare FSA available if you enroll in the Gold, OOA Gold, Silver or Bronze HSA Medical Option

The Dependent Care FSA can be elected regardless of your medical option, but your eligibility does depend on the ages of your dependents and whether you expect to have qualifying dependent care expenses.

Determining Contributions and Enrolling

When you enroll in an FSA, you must select the type of FSA that you are electing, and you must specify your contribution amount. Your contribution is credited to your FSA each pay period while you are on active payroll, for pilots, with each disability payment while you are receiving benefit payments from the Delta Pilots Disability and Survivorship Plan. Pre-tax contributions for the Healthcare FSA also continue automatically for ground, flight dispatcher or flight attendant employees who are receiving paid maternity leave, certified time or 66.67% OJI pay (through the end of the year only). Any contributions you make to the Healthcare FSA on an after-tax basis while inactive for ground, flight dispatcher or flight attendant employees or while on an inactive status other than disability for pilot employees are credited as well. However, for ground, flight dispatcher or flight attendant employees, once on inactive status, including disability, your eligibility for the Dependent Care FSA ends.

Each year, you should carefully determine how much money to set aside for unreimbursed eligible healthcare (medical, dental and/or vision) and/or dependent care expenses for yourself and your dependents. To do this, estimate the expenses that you expect to incur during the coming year. According to IRS regulations, any money that is left in your account at the end of the year (with some exceptions for the Healthcare FSA described under "The 'Use It or Lose It' Rule" later in this "Flexible Spending Accounts" section of the handbook) cannot be returned to you. This means you could forfeit amounts; you should plan very carefully.

Contribution Limits

- Healthcare FSA: For 2019, you may contribute up to \$2,650 pre-tax dollars annually
- Dependent Care FSA: For 2019, you may contribute up to \$5,000 pre-tax dollars annually

Enrolling in Both Spending Accounts

Keep in mind that the Healthcare FSA and Dependent Care FSA are completely separate accounts. You cannot use money from one account to pay Eligible Expenses under the other account. For instance, you cannot pay day care expenses with contributions you have made to the Healthcare FSA.

Changing Your FSA Contributions During the Year

You may not change your FSA contributions during the calendar year unless you experience certain qualified life events or status changes. Some qualified life events or status changes may make you eligible to increase your contribution to the Healthcare FSA, or to increase or decrease your Dependent Care FSA contributions. You may make these changes to your FSA(s) as long as the changes are consistent with your qualified life event/status change.

You must report your qualified life events and status changes to the Employee Service Center (ESC) within 60 days of the event. If you do not do so, you cannot change your current election until the next annual open enrollment period.

See the "Life Events" section of this handbook for more information about allowable status changes and how to report them.

Filing for Reimbursement

FSA's are designed to pay for Eligible Expenses incurred during the calendar year, January 1 – December 31. An expense is incurred when a medical or dependent care service is rendered, not when you pay the expense.

You have until March 31 of the following year to submit a request for reimbursement of expenses incurred during the current year. For example, orthodontia treatment is normally provided over a two (2) year period. If you pay for the entire treatment in full up front, you will be unable to file and obtain reimbursement of that expense until you or your child has actually received such treatment or incurred the expense.

Planning Note: *Over-the-counter medications are **only** eligible for reimbursement from an FSA if they are prescribed by a doctor.* This means that any non-prescribed over-the-counter medications are not eligible for reimbursement.

The IRS requires you to provide acceptable documentation with all requests for reimbursement of out-of-pocket purchases before a reimbursement from an FSA can be authorized. Acceptable supporting documentation is the record of information that validates a reimbursable expense. **Only expenses that can be substantiated with acceptable documentation can be reimbursed.**

Acceptable documentation must:

- Be prepared by an independent third party
- Clearly demonstrate that the expense was incurred by you or your Spouse, children or other tax dependent(s)

It must contain:

- The name of the person or entity providing the service
- The name of the person receiving the service
- The nature of the service provided
- The date the service was provided
- The total amount of the expense

Tips for submitting successful claims for reimbursement:

- Explanation of Benefits (EOB) statements are the best form of documentation for healthcare expenses
- Make sure that all documentation can be easily read
- Circling an item is more effective than using a highlighting marker to set it apart
- "Balance Due" bills, credit card receipts, cancelled checks or simple payment receipts are not considered sufficient or acceptable documentation

The "Use It or Lose It" Rule

Healthcare FSA with Carry Over

If you are unable to use all of your Healthcare FSA dollars by the end of the calendar year, as permitted by the IRS, up to \$500 will automatically carry over for you to use the next calendar year. Any amount carried over will be in addition to your Healthcare FSA contributions in that calendar year, so it is important to consider carried over FSA dollars when you make your Healthcare FSA elections. This carryover provision applies to both the Full Purpose and Limited Purpose Healthcare FSA.

Any amount over \$500 that you do not use to reimburse yourself for Eligible Expenses incurred during the calendar year your election is in place or for which you do not file a claim by the filing deadline noted above will be forfeited.

Up to \$500 of unused Healthcare FSA funds can be carried over each year, as long as you continue to enroll in the Healthcare FSA. If you have a remaining amount of \$500 or less for a year and do not enroll in the Healthcare FSA for the next calendar year, you will carryover that amount for use in that following year only. Any remaining carried over amount will be forfeited at the end of that year. For example, if you have \$500 of unused funds in your Healthcare FSA from the 2018 plan year, this amount will carry over for you to use in 2019. If you do not enroll in the Healthcare FSA for 2019, the carryover funds must be used in 2019 and will not be carried over to 2020.

Dependent Care FSA

The carryover rule described above for the Healthcare FSA does not apply to the Dependent Care FSA. This means that you forfeit any money you contribute to your Dependent Care FSA that you do not use to reimburse yourself for Eligible Expenses incurred during the calendar year your election is in place or for which you do not file a claim by the filing deadline noted above.

This "use it or lose it" rule illustrates why it is important to set aside only the amount of money that you believe you will spend during the year. If you estimate your expenses carefully, you reduce the likelihood of forfeiting unused money.

Keeping Track of Your Accounts

Each quarter, UHC provides an FSA statement of account balances to you. In addition, the FSA Explanation of Benefits (EOB) accompanies each reimbursement check. To check your balance or for information about your account, call Delta Health Direct at **877-912-1820**. You also may visit the UHC website at **myuhc.com**.

Tax Considerations and Their Effect on Your Social Security Benefit

It is important to note that the IRS may permit you to take a federal tax credit or deduction on your income tax return for medical and/or dependent care expenses. However, the amount deposited in your FSA reduces, dollar-for-dollar, the amount allowed toward the federal tax credit or deduction. You cannot take as a tax deduction or credit the amount of your FSA, or the amount of expenses reimbursed through your FSA.

Your tax savings may be greater if you participate in an FSA. Or, you may find that your tax savings are greater if you take a tax credit on your annual income tax return.

Also note that salary reduction contributions and, for pilots, any contributions from your temporary disability benefits from the Delta Pilots Disability and Survivorship Plan reduce your FICA, and thus could reduce the Social Security benefit for which you are eligible.

You may wish to consult a tax advisor to discuss the use of these FSAs and whether the FSA or the tax credit is better for you financially.

Healthcare FSAs

The Healthcare FSA provides a tax-advantaged way to help you pay for eligible out-of-pocket healthcare expenses that are not covered by another benefit plan or reimbursement account. You may use this account to pay healthcare expenses for yourself and any eligible tax dependents, regardless of whether you or your dependents are enrolled in a Delta Medical Plan.

You cannot take a federal tax credit deduction and be reimbursed from the Healthcare FSA for the same expense.

Your Contributions

You may contribute up to \$2,650 annually on a pre-tax basis to your Healthcare FSA. The minimum contribution that you can make is \$120 annually.

Your pre-tax contributions to your Healthcare FSA are made from your active paycheck or from some types of disability pay as described previously under "Who is Eligible" earlier in this "Flexible Spending Accounts" section of the handbook.

If you and your Spouse both work for Delta, you may each contribute up to the maximum amount annually to your Healthcare FSA; however, both of you cannot claim the same expenses for reimbursement.

Only if you have a qualified life event change can you start or increase your Healthcare FSA contribution amount during the year. You cannot decrease your Healthcare FSA contribution. See the "Life Events" section of this handbook for details.

Your Dependents

Only Eligible Expenses for you and your eligible tax dependents are reimbursable from your Healthcare FSA. Generally, your Spouse and children qualify as your tax dependents under federal tax law, but other individuals may also qualify if they are your tax dependent under federal tax law. For more information, go to www.irs.gov.

Full Purpose FSA

If you are enrolled in the HRA or OOA HRA Medical Option or you are enrolled in "No Coverage" and want to contribute to Delta's Healthcare FSA, your FSA is a Full Purpose FSA. As a traditional healthcare FSA, the Full Purpose FSA can be used to pay medical, dental, vision, prescription drug, physician-prescribed over-the-counter medications and other eligible over-the-counter items that qualify as Eligible Expenses. You are not eligible to participate in a Full Purpose FSA if you enroll in any of the HSA Medical Options.

Using Your Full-Purpose FSA With an HRA Medical Option

You may use your FSA to pay Eligible Expenses for you and your eligible tax dependents.

The first day your Healthcare FSA benefit election becomes effective, your entire annual contribution amount is available to reimburse the Eligible Expenses of you and your eligible tax dependents. However, when you or your dependents have a covered medical expense, your HRA dollars from the HRA Medical Option must be used first. This happens automatically and is not optional. If you have more covered healthcare expenses than you have HRA dollars, you must pay those expenses out of pocket. You can choose to reimburse yourself with your Healthcare FSA contributions.

HRA dollars are not used to pay for dental, vision, prescription drug, physician-prescribed over-the-counter medications and other eligible over-the-counter items. However, Healthcare FSA funds are available for reimbursement of those expenses, if they are Eligible Expenses, on the first day your benefit election is effective.

Be sure to plan for the use of your annual FSA election amount by December 31. You may carry over \$500 of unused funds in your Healthcare FSA but forfeit any amount over \$500 (the allowed carryover amount) that is not used to reimburse Eligible Expenses you incurred during that year.

Using Your Full-Purpose FSA With Options Other Than an HRA Medical Option, Including "No Coverage"

The first day your Healthcare FSA benefit election becomes effective, your entire annual contribution amount is available to reimburse the Eligible Expenses of you and your eligible tax dependents. When you have an Eligible Expense that is not covered by insurance or otherwise reimbursed to you, you may choose to reimburse yourself with these FSA dollars.

You may use your Healthcare FSA to pay medical, prescription drug, physician-prescribed over-the-counter medications and other eligible over-the-counter items, dental and vision expenses that qualify as Eligible Expenses, and for which you do not receive insurance coverage or reimbursement. This includes medical and prescription drug Copays and Coinsurance.

Be sure to plan for the use of your annual FSA election amount by December 31. You may carry over \$500 of unused funds in your Healthcare FSA but forfeit any amount over \$500 (the allowed carryover amount) that is not used to reimburse Eligible Expenses you incurred during that year.

Limited Purpose FSA

The Limited Purpose FSA is the only Healthcare FSA that can be used in conjunction with the Gold, OOA Gold, Silver or Bronze HSA Medical Option. You cannot participate in both an HSA Medical Option and the Full Purpose FSA. So, if you enroll in an HSA Medical Option and want to contribute to Delta's Healthcare FSA, your FSA is a Limited Purpose FSA.

Prior to meeting your Deductible, you may not reimburse yourself for eligible medical expenses from the Limited Purpose FSA because this will render you ineligible to contribute to an HSA. If you have a Post-Deductible HRA (because you moved from an HRA Medical Option to the HSA Medical Option

when you had an HRA balance), this Post-Deductible HRA will automatically pay toward your Deductible after you reach the minimum IRS deductible required of an HSA (for 2019, this is \$1,350 for employee and \$2,700 for other coverage). Once your Post-Deductible HRA, if any, has been exhausted, you may use your Limited Purpose FSA to reimburse any Eligible Expenses you pay prior to reaching your Annual Coinsurance Maximum.

Be sure to plan for the use of your annual Limited Purpose FSA election amount by December 31. You may carry over \$500 of unused funds in your Limited Purpose Healthcare FSA but forfeit any amount over \$500 (the allowed carryover amount) that is not used to reimburse Eligible Expenses you incurred during that year.

Eligible Expenses

Generally, healthcare expenses considered tax deductible by the IRS can be reimbursed through your Healthcare FSA.

Following is a list of the types of expenses that the IRS has deemed tax deductible. You can be reimbursed for these expenses if they have not been paid by another medical, dental or vision plan or been reimbursed from a healthcare account.

Note that medical (other than unreimbursed preventive care), prescription drug, and certain over the counter expenses are not Eligible Expenses for the Limited Purpose FSA until after your Deductible is met.

- Copayments, Deductibles and Coinsurance for medical, vision, pharmacy and/or dental plans
- Charges above plan maximums, Reasonable and Customary (R&C) limits and Medicare Reimbursement Rates
- Certain over-the-counter items, such as bandages
- Over-the-counter medications only if prescribed by a doctor (Note: Proof of prescription will be required for reimbursement)
- Eye exams, prescription glasses and sunglasses, contact lenses, solutions and other supplies not covered under a vision plan
- Orthodontia
- Laser eye surgery
- Acupuncture
- Braille books and magazines
- Smoking cessation prescriptions
- Service animals for the blind
- Special telephones for the deaf
- Hearing devices
- Christian Science practitioners' fees

List of Eligible Healthcare Expenses

For a complete list of the types of eligible healthcare expenses that may be reimbursed through an FSA, visit UHC at myuhc.com, visit the IRS website at irs.gov/pub/irs-pdf/p502.pdf or contact your local IRS office to ask for Publication 502.

Ineligible Healthcare Expenses

The following are examples of healthcare expenses that do not qualify for reimbursement from your Healthcare FSA, under IRS guidelines:

- Medical, dental, vision and other health plan Premium contributions*
- Athletic club memberships
- Non-prescribed weight loss plans
- Over-the-counter medications that are not prescribed by a physician
- Cosmetic surgery unrelated to illness or disease
- Maternity clothes
- Hair growth drugs or transplants
- Hair removal drugs or surgery
- Vitamins, minerals, nutritional supplements or herbal supplements
- Funeral expenses
- The portion of your expenses that are reimbursed under your medical plan, dental plan or vision plan, or from medical, dental or vision coverage from any other sources (including a Health Savings Account or an FSA in which your Spouse participates)
- Swimming pool, hot tub or spa installation or usage fees
- Naturopath/homeopath fees

Dependent Care FSA

The Dependent Care FSA provides a tax-advantaged way to help you pay for work-related day care expenses, such as certain child day care and elder day care costs, as well as in-home child care. To be eligible for coverage, the dependent care expenses must be necessary for you and your Spouse to work.

Find Dependent Care In Your Area

Delta's Employee Assistance Program (EAP) provides resources to help you find day care and elder care facilities in your neighborhood. Visit Delta's EAP website located on Deltanet.

Your Contributions

You may contribute up to \$5,000 annually on a pre-tax basis to your Dependent Care FSA if you are single, married, separated or divorced. The minimum contribution that you can make is \$120 annually.

Your pre-tax contributions to your Dependent Care FSA are made from your active paycheck. Additionally, if you are a pilot on active pay status while contributing to the Dependent Care FSA and begin receiving disability benefits from the Delta Pilots Disability and Survivorship Plan during the year, you continue to have pre-tax contributions to your Dependent Care FSA deducted from your disability pay. For ground, flight dispatcher or flight attendant employees or a pilot who goes on any other paid inactive status, you may not continue your Dependent Care FSA contributions.

* Generally, the types of expenses that are deductible medical expenses under Tax Code Section 213 and IRS Publication 502 are considered Eligible Expenses under the FSA. However, although listed in Publication 502, health insurance Premiums (including any medical fee listed on a school tuition bill) are not reimbursable under the FSA, according to federal law.

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In addition, the following limitations apply.

If This Is Your Situation ...	Then, Your Maximum Annual Contribution Is ...
You or your Spouse earn less than \$5,000 a year	The lower of your two incomes
Your Spouse also participates in a dependent care FSA	Up to a \$5,000 combined contribution for both accounts
You and your Spouse file separate federal income tax returns	Up to \$2,500 per person
Your Spouse is a full-time student or is disabled	\$200 for each month your Spouse is a full-time student; up to \$2,400 if you have one dependent \$400 for each month your Spouse is a full-time student; up to \$4,800 if you have two or more dependents

Your Dependents

For the Dependent Care FSA, eligible tax dependents include:

- Your children or other dependents under age 13 for whom you can claim a tax deduction
- Your legal Spouse who is physically or mentally incapable of caring for himself or herself
- Other dependents of any age who are mentally or physically incapable of caring for themselves — this dependent must qualify as your tax dependent under the Internal Revenue Code

Special rules may apply in the case of divorce.

Eligible Dependent Care Expenses

Generally, you may reimburse through your Dependent Care FSA any day care expenses for which you could receive a federal tax credit if your income were within IRS limits. **Also, for these dependent care expenses to be eligible for reimbursement they must be work-related — that is, incurred as a way of permitting you to work.**

Following is a list of the types of expenses that the IRS has deemed eligible for reimbursement through a Dependent Care FSA:

- After-school care or summer day camp for children under age 13
- Day care or elder care inside or outside the home by anyone other than a dependent claimed on your tax return, or by a child under age 13
- Day care, child care and elder care centers (if the day/child care center looks after more than six children, it must comply with state and local regulations)
- Care provided by a housekeeper whose primary responsibility is to care for an eligible tax dependent
- Education expenses for a child not yet in kindergarten (such as nursery school or preschool expenses)
- Taxes you may pay for eligible providers

Tax law requires you to report the Taxpayer Identification Number (TIN) of the organization that provides day care services. However, if the dependent care provider is a tax-exempt organization of the type described in Section 501(c)(3) of the Internal Revenue Code, no TIN is required. If you pay an individual for day care services, you must report that individual's Social Security number.

List of Eligible Dependent Care Expenses

For a complete list of the type of expenses the IRS considers eligible dependent care expenses, visit UHC at **myuhc.com**, visit the IRS website at **irs.gov/pub/irs-pdf/p503.pdf** or contact your local IRS office to ask for Publication 503.

Ineligible Dependent Care Expenses

The following are examples of dependent care expenses that do not qualify for reimbursement under IRS guidelines:

- Expenses for food, clothing or entertainment
- Child support payments
- Private school tuition
- Expenses for overnight camps
- Expenses for enrichment programs, such as gymnastics, swimming and ballet
- General babysitting other than during work hours
- Transportation expenses
- Education expenses for a child in kindergarten or a later grade
- Nursing home expenses
- Payments made to a Spouse or to any person declared as a dependent for income tax purposes
- Expenses incurred while you are on a leave of absence

Reimbursements

You can receive Healthcare FSA or Dependent Care FSA reimbursements in the following ways:

- Electronic Funds Transfer/direct deposit
- Automatic Payment Option (Healthcare FSA or Limited Purpose FSA)
- FSA claim forms
- Prescription Drug FSA Debit Card for prescription drug expenses incurred at any participating UHC network pharmacy (available for the Full Purpose FSA only)

Electronic Funds Transfer/Direct Deposit

If you have a checking or savings account in a U.S. banking institution that accepts electronic funds transfers (EFTs), your FSA reimbursements can be direct deposited. If you have an FSA, you may sign up for this option at **myuhc.com**.

- Go to the UnitedHealthcare website at **myuhc.com**; you need your User Name and Password to enter
- Locate and Click on "Account Settings"
- Select "Direct Deposit for Claim Reimbursement" under "Account Preferences" and update the "Direct Deposit Status" and "Bank Account Information"

You can sign up for direct deposit at any time during the year. Once you enroll in the direct deposit option and that option becomes effective, all reimbursements are processed through direct deposit to your account on file for as long as you are enrolled in the FSA program — unless you return to **myuhc.com** and change or stop the direct deposits. Remember, if you change banks, you need to change your account information at **myuhc.com**.

Once your direct deposit option has been set up, eligible future FSA payments are deposited in your bank account.

Healthcare Flexible Spending Account Automatic Payment Option

If you are enrolled in the Healthcare FSA or Limited Purpose Healthcare FSA, you may enroll in the automatic payment option each year online at **myuhc.com**.

- Go to the UnitedHealthcare website at **myuhc.com**; you need your User Name and Password to enter
- Locate and Click on "Account Settings"
- Select "Automatic FSA/HRA Payment Options" under "Account Preferences" and complete the enrollment process

This option works differently depending on the medical option in which you are enrolled.

- *If you are enrolled in an HRA Medical Option*, your HRA dollars are automatically used first when you incur covered medical expenses. These expenses are not sent for automatic payment from your FSA. If you have more covered medical expenses than you have HRA dollars and you are enrolled in the automatic payment option, those expenses are automatically submitted on your behalf to your Full-Purpose Healthcare FSA for payment. Additionally, your claims for any eligible out-of-pocket expenses (such as Coinsurance, Deductibles and prescription drug expenses) under that plan option or dental and vision out-of-pocket expenses can automatically be submitted to your Full-Purpose Healthcare FSA on your behalf
- *If you are enrolled in an HSA Medical Option*, your eligible dental and vision out-of-pocket expenses and your out-of-pocket medical expenses after you meet your medical plan deductible under that plan option can automatically be submitted to your Limited Purpose Healthcare FSA on your behalf. If you use this automatic payment option for your Limited Purpose Healthcare FSA, these eligible expenses will be automatically reimbursed from your Limited Purpose Healthcare FSA; you should use caution when using your HSA because you may not use your HSA to reimburse yourself for those same expenses that are automatically reimbursed from your Limited Purpose Healthcare FSA. If duplicate reimbursement occurs, you must reimburse your HSA to avoid tax implications. If you also have a post-deductible HRA, reimbursements will be paid from that balance before paying from your Limited Purpose Healthcare FSA

If you are setting up the automatic payment option for the first time, note that the process can take up to 10 days to complete. If you participate in the automatic payment option, once your claim is filed, eligible reimbursements are automatically sent through electronic funds transfer (EFT) to the U.S. bank account on file, if you have direct deposit, or through a paper check mailed to your home address on file.

The automatic payment option is not available for dependent care claims or medical claims before you meet your medical plan deductible if you are enrolled in an HSA Medical Option or healthcare expenses from providers other than UHC. For example, if you and your children are covered through a supplemental plan, such as your Spouse's plan through another employer, you should not elect to participate in the automatic payment option.

FSA Claim Forms

Unless you have elected the automatic payment option for your medical, dental, vision or prescription FSA expenses, you must file a request for reimbursement of an Eligible Expense.

To file an electronic claim form, follow these directions:

- Go to the UnitedHealthcare website at **myuhc.com**; you need your User Name and Password to enter
- Click on "Claims & Accounts"
- Select "Submit Online FSA/HRA Form" under "Forms" and complete the submission process

To file a manual claim form, follow these directions:

- Get an FSA claim form through one of these methods:
 - Call Delta Health Direct at **877-912-1820**
 - Visit **myuhc.com**
 - Search for FSA Claim Form on Deltanet
- Carefully complete all information required on the form and sign it
- Submit the completed form, along with required supporting documentation, to UHC at the address or fax number shown on the form
- Make a copy of your claim for your records

You may submit requests for reimbursement as often as you like. However, you will not be reimbursed for claim amounts higher than the balance in your Dependent Care FSA account at the time you submit the claim form. Reimbursements from the Healthcare FSA and Dependent Care FSA are processed weekly and mailed to your home, unless you enrolled for direct deposit into your bank account.

If you have enrolled in the automatic payment option of the Healthcare FSA, you only need to file a claim form for the eligible medical, dental or vision expenses that are not automatically rolled over to the FSA administrator. See "Healthcare Flexible Spending Account Automatic Payment Option" earlier in this section for details. However, you must always file claims for your eligible dependent care expenses, because those do not qualify for the automatic payment option, and, therefore, do not roll over to the FSA administrator.

Supporting Documentation

Acceptable supporting documents for reimbursement may include:

- Explanations of Benefits (EOBs)
- Receipts
- Superbills or invoices

Canceled checks are not allowable documentation for Dependent Care FSA submissions.

Prescription Drug FSA Debit Card

If you are enrolled in the Full Purpose Healthcare FSA, you have immediate access to your account through the Prescription Drug FSA Debit Card.

The card can only be used for prescription drug expenses incurred at any participating UHC network pharmacy. If you attempt to purchase ineligible expenses with the card, the eligible items will be applied to your FSA, and you will have to pay for ineligible items separately with other funds.

When making a purchase, your Prescription Drug FSA Debit Card does not have to have a sufficient balance in order to purchase your eligible items. However, if the purchase is greater than your remaining annual elected amount, the remaining amount will be applied toward your purchase and any remaining balance will have to be supplied through another payment method (for example, your own checking account or cash).

Transactions that are purchased with the card at the point of sale are automatically validated by UHC. However, UHC recommends that you keep your receipts for future verification, if you are audited.

The Prescription Drug FSA Debit Card is automatically sent to you when you enroll in the Full Purpose FSA. Your card is loaded with your entire FSA annual election amount each year you enroll in a Full Purpose FSA. Note that this card is not available to participants who are enrolled in the Limited Purpose FSA.

Minimum Reimbursements

When you file a Healthcare FSA or Dependent Care FSA manual claim, there is a minimum reimbursement amount of \$25. Any claim for less than \$25 is held until you submit other claims and the total amount claimed exceeds \$25. The \$25 minimum check amount does not apply when submitting final claims that will exhaust the account, nor does the minimum apply at the end of the calendar year.

Timing of Reimbursements

Healthcare FSA reimbursements are processed differently from Dependent Care FSA reimbursements.

- **Healthcare FSA:** The full amount of your annual election for this account is immediately available to you for reimbursement of Eligible Expenses due to federal law. Advance reimbursement cannot exceed your total annual election amount. Reimbursements are processed weekly
- **Dependent Care FSA:** Reimbursement from your Dependent Care Account cannot exceed the actual amount contributed to your account, and may not be filed before services are provided — even if you have already paid for them. Reimbursements are processed weekly up to the current balance amount. If you do not have sufficient funds for claims submitted, your claim is pended until future contributions are deposited to the account

Example

You elect an annual contribution of \$300 to each FSA.

If you pay \$300 for an eligible healthcare service, but you only have \$200 in your account at the time you submit your claim, you will be reimbursed for the full amount of \$300 when your claim is processed.

If you pay \$300 for an eligible dependent care service, but you only have \$200 in your account at the time you submit your claim, you will be reimbursed \$200 when your claim is processed. The remaining \$100 will be pended and sent once sufficient additional deposits have been credited to your account.

Claim Denial and Appeal

You have the legal right to appeal a denied Healthcare FSA reimbursement request. For details about the appeal process, see the "Claims Information & Appeals" section of this handbook.

The Dependent Care FSA does not have a formal appeals process, and one is not legally mandated. However, if one of your claims is denied, UHC reviews it with you and considers any additional information you may have.

If You Become Inactive or Leave Delta

If you are enrolled in coverage and start receiving benefits from the Delta Disability and Survivorship Plan, special rules apply to your FSA eligibility:

- Ground, flight dispatcher and flight attendant employees: If you are receiving paid maternity leave, certified time or 66.67% OJI pay, your pre-tax contributions to your Healthcare FSA will automatically continue through the end of the calendar year while receiving this type of pay. If you are receiving short-term disability (STD) benefits or long-term disability (LTD) benefits, your Healthcare FSA contributions are automatically taken from your STD or LTD pay through the end of the calendar year on a post-tax basis. Your contributions to the Dependent care FSA automatically stop when you go on any inactive status. See the *Disability Benefits Handbook* for more information on paid maternity leave, certified time, 66.67% OJI pay or disability benefits. For unpaid leaves, you are billed for Healthcare FSA contributions through the end of the year after you miss two payroll deductions.
- Pilots: If you are making pre-tax payroll deductions to the Healthcare FSA and/or the Dependent Care FSA at the time you start receiving disability or paid maternity leave benefits from the Delta Pilots Disability and Survivorship Plan during the year, your pre-tax contributions to your Healthcare FSA and/or Dependent Care FSA will be deducted from your disability or maternity leave pay. For unpaid leaves, you are billed for Healthcare FSA and/or Dependent Care FSA contributions through the end of the year after you miss two payroll deductions.

For more information, please see the "Eligibility" section of this handbook - under the "Eligible Participants" heading, look for section called "Disabled Employees").

If you leave Delta during the year, or if your disability benefits cease, and you had an FSA election in effect, you can submit claims for Eligible Expenses incurred before the date your contributions ceased. See the next section regarding COBRA rights that may apply after your termination of employment, or the cessation of disability benefits.

An expense is incurred when the services that result in the expense are rendered, not when you pay the expense.

COBRA Continuation Coverage

You may temporarily continue your Healthcare FSA participation on an after-tax basis when you experience a loss of eligibility due to a qualifying life event, such as termination of employment. (This provision is required as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA.) See the "COBRA Continuation Coverage" section of this handbook for COBRA coverage rules.

- **If you elect to continue coverage for your Healthcare FSA** — You must elect COBRA continuation coverage and make your monthly after-tax contributions (plus a 2% administrative fee) to the account in a timely manner. This continuation coverage is solely at your or your family member's expense. Conduent HR Services LLC for Delta Air Lines mails the COBRA enrollment package to you
- **If you do not elect to continue your Healthcare FSA through COBRA** — Any expenses incurred while you are not on active pay status or, for pilots, while receiving disability benefits from the Delta Pilots Disability and Survivorship Plan are not eligible for reimbursement from the account

You may not continue your Dependent Care FSA after you become an inactive or terminated employee, other than a pilot whose contributions continue while receiving disability benefits from the Delta Pilots Disability and Survivorship Plan.

FSA Questions?

If you have questions about FSAs, contact Delta Health Direct at **877-912-1820** or visit **myuhc.com**.

DENTAL BENEFITS

DENTAL BENEFITS

Brushing after meals and routinely flossing are important to maintaining the health of your teeth. Other measures to prevent tooth decay and loss, including regular visits to your dentist, also are part of a healthy dental care routine. The dental coverage offered by Delta encourages routine preventive services and good dental health.

The Delta Account-Based Healthcare Plan (DABHP) offers you a choice of two self-insured dental options administered by Metropolitan Life Insurance Company (MetLife) — the Basic Dental Option and the Comprehensive Dental Option.

With both dental options, you can choose to see any dentist; but, by using a dentist in MetLife's PDP Plus network, you can lower your costs and make the most of your dental plan. This is because participating dentists have agreed to accept negotiated payments that are generally lower than average fees charged in a dentist's community for similar services. Also, when visiting participating dentists, negotiated fees may extend to non-covered services and services provided after plan maximums are exceeded — and this can mean even more savings for you. Non-participating dentists haven't agreed to accept negotiated fees. So you may pay more for the same service if you use a non-participating dentist. See "Key Features of the MetLife Dental Options" later in this "Dental Benefits" section for more information.

The dental options offered under the Delta Account-Based Healthcare Plan (DABHP) are sometimes referred to as "MetLife dental options" in this handbook; however, they are not insured by MetLife — claims are paid by Delta.

Each dental option offered varies in the level and type of coverage provided.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

Coverage Tiers

You may choose from four coverage tiers.

Coverage Tier	Who Is Covered
Employee Only	Yourself only
Employee & Spouse	You and your eligible Spouse
Employee & Child(ren)	You and your eligible child(ren)
Family	You, your Spouse, and one or more eligible children

Under the DABHP, the coverage tier you elect for dental benefits does not have to be the same as the tier you elect for your medical and/or vision coverage. For example, you may elect family dental coverage and employee only medical coverage.

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If you enroll dependents, you must elect the same dental coverage option for yourself and your dependents. For example, you may not elect the Basic Dental Option for yourself and the Comprehensive Dental Option for your dependents.

Refer to the "Eligibility" section of this handbook for eligibility criteria for dental coverage.

Waiving Coverage

In the DABHP, you may enroll in dental coverage and waive medical coverage. Or you may choose to enroll in medical coverage and waive dental coverage. You waive dental coverage for yourself and your dependents by selecting the "No Coverage" dental option during enrollment. Before you waive dental coverage, you should be aware of the consequences, as outlined in the following chart.

If You Are Eligible As ...	And You Choose the "No Coverage" Option ...
An active employee	You waive dental coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot obtain coverage for the calendar year unless: <ul style="list-style-type: none"> • You or your dependent experience certain special enrollment events (see the "Life Events" section of this handbook) • You retire from Delta and qualify for retiree healthcare benefits, or • You die and your survivors are eligible for survivor healthcare benefits (see the "Eligibility" section of this handbook)
An active employee who becomes disabled or inactive An inactive or disabled employee	You cannot enroll in dental coverage until you return to active pay status unless you or your dependent experience an eligible special enrollment event (see the "Life Events" section of this handbook)
An active employee who retires during the year	You may enroll for dental coverage at the time of your retirement and during future annual retiree open enrollment periods if you qualify for retiree healthcare benefits upon retirement (see the "Eligibility" section of this handbook)
An active, inactive or retired employee, and you die	Your eligible survivors may enroll for coverage at the time of your death and during future annual open enrollment periods as long as they remain eligible (see the "Eligibility" section of this handbook for survivor healthcare eligibility rules)
A retired participant	You waive dental coverage for yourself and your eligible family members for the entire year. You and your eligible dependents cannot obtain coverage for the calendar year unless you or your dependent experience certain special enrollment events (see the "Life Events" section of this handbook) or you die and your survivors are eligible for survivor healthcare benefits (see the "Eligibility" section of this handbook for survivor healthcare eligibility rules)
A survivor eligible for Delta healthcare benefits	You waive dental coverage for the entire year
A COBRA participant	You waive your right to elect Delta dental coverage forever

Overview of the MetLife Dental Options

Through the DABHP, you can choose coverage under the Basic Dental Option or the Comprehensive Dental Option. Both options are administered by MetLife. Refer to the following charts for coverage details about these options.

Basic Dental Option

- Provides basic dental coverage, including:
 - 100% coverage for preventive services with no deductible
 - 70% coverage for basic restorative services with no deductible
- You receive care from your choice of dentists
- The annual maximum benefit is \$600 per person

Comprehensive Dental Option

- Provides comprehensive dental coverage, including:
 - 100% coverage for preventive services; not subject to the deductible
 - 70% coverage for basic restorative services after you meet the deductible
 - 50% coverage for major restorative services after you meet the deductible
 - 50% coverage for orthodontic services after you meet the deductible. Orthodontic services are only covered for enrolled dependent children up to age 26. Please note that treatment that began for a covered adult before January 1, 2017 is covered up to the \$3,000 lifetime orthodontia maximum benefit as long as the individual remains enrolled in the Comprehensive Dental Option
- You receive care from your choice of dentists
- The annual maximum benefit is \$2,000 per person
- The lifetime orthodontia maximum benefit is \$3,000 per person

Key Features of the MetLife Dental Options

MetLife Participating Dentists – The PDP Plus Network

The percentage that the plan pays for certain covered expenses is the same regardless of whether you use a dentist who participates in MetLife's PDP plus network, but you can reduce the amount you pay out of pocket and the amount Delta pays simply by using a participating dentist. Participating dentists have agreed to use MetLife's discounted negotiated fees. Through the PDP Plus Network, you can choose from more than 256,000 credentialed participating dentist locations nationwide.

Also, there are no claim forms to fill out — your participating dentist handles all of the paperwork. MetLife directly reimburses participating dentists the amount of the plan benefit.

To find a participating dentist or specialist, visit www.metlife.com/mybenefits and type in the company name ("Delta Air Lines"), or call the MetLife Dental Customer Service Center at **855-700-7992**.

Using PDP Plus Network Dentists

You can reduce the amount you pay out of pocket and the amount Delta pays simply by using a dentist that participates in MetLife's PDP Plus network.

When you use a participating dentist, the plan's share of covered expenses is based on a negotiated fee, or, if lower, the Reasonable and Customary (R&C) charge for the service or supply. When you use a non-participating dentist, the plan's share of covered expenses is based on the R&C charge, which may be higher than the negotiated charge a participating dentist charges. And, if a non-participating dentist's charges are higher than the R&C charge, you may be responsible for paying any difference and may pay even more for the same service or supply.

For example, suppose your MetLife dental option pays 70% for a Covered Service and you chose to use a non-participating dentist. If the R&C charge for that service is \$400 and you have met your deductible (if applicable), your share would be \$120 (30% of \$400) plus any amount over the R&C charge. However, if the negotiated fee for that service is \$250, because you use a participating dentist, your share would be only \$75 (30% of \$250).

To find a participating dentist or specialist, visit www.metlife.com/mybenefits and type in the company name ("Delta Air Lines"), or call the MetLife Dental Customer Service Center at **855-700-7992**.

Non-Participating Dentists

You may choose to see a non-participating dentist for your dental care. If you see a non-participating dentist, benefit payments for this dental care are based on Reasonable and Customary (R&C) charges as determined by the claims administrator (MetLife).

Amounts over the R&C charge limits are not Covered Expenses under the plan — you must pay 100% of those amounts. In addition, amounts over R&C charge limits do not count toward your deductible (if applicable). Your payment is based on a percentage of the R&C charge for a covered dental expense.

Non-participating dentist can submit claims to MetLife for payment. Claim reimbursement will be issued to the non-participating dentist for covered services. You will be responsible for any additional payment owed to the non-participating dentist. However, non-participating dentists are not required to file your claim with MetLife so it may be your responsibility to pay the non-participating dentist and file a claim for reimbursement.

Specialty Services Provided By a Non-Participating Dentist

If you need a covered service provided by a specialty dentist and there is not a MetLife participating dentist within a 30-mile radius of your home, you may be eligible to receive benefits for services by a non-participating dentist at the network level. Contact MetLife at **855-700-7992** before services are provided by a non-participating specialty dentist. A customer service representative will help you to determine if there are alternatives, for example, by checking to see if additional in-network specialists have recently been added to your area.

International Dental Travel Assistance

Chipped a tooth, lost a filling or crown while traveling internationally? No need to worry, because through MetLife's International Dental Travel Assistance program, you can get a referral to a local dentist for immediate care until you can see your regular dentist. This service is available 24/7 with access to international dental providers in over 200 countries. With just one phone call you will be connected to a multi-lingual assistance coordinator that will gather all the necessary information to help you get the care you need. Best of all, International Dental Travel Assistance is automatically available to you and your covered dependents and there is no need to enroll.

The applicable coverage percentage will be applied to the international providers' charges and converted into U.S. dollars based on the conversion rate in place on the date services are performed. Hold on to all receipts to submit a dental claim.

Questions? If you are in the U.S. and planning an international trip call 888-558-2704. When traveling internationally, call collect +1 (312) 356-5970 any time for a dental referral.

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Basic Dental Option Coverage Chart

2019 Dental Benefit	Coverage	
	PDP Plus Network Dentist	Non-Participating Dentist
Annual Maximum Benefit	\$600 per person	
Annual Deductible	None	
Preventive Services	100% of the negotiated charge	100% of R&C
Basic Restorative Services (Such as fillings, extractions, root canals, periodontal procedures)	70% of the negotiated charge	70% of R&C
Major Restorative Services (Such as crowns, bridges, inlays, onlays)	Not covered	
Dental Oral Surgeries	Not covered	
Prosthetics	Not covered	
Orthodontic Services	Not covered	
Lifetime TMJ Maximum Benefit*	\$500 per person	

* Amounts applied up to a covered person's TMJ maximum are included when determining when that person has met his or her annual maximum benefit.

HEALTHCARE BENEFITS HANDBOOK

Comprehensive Dental Option Coverage Chart

2019 Dental Benefit	Coverage	
	PDP Plus Network Dentist	Non-Participating Dentist
Annual Maximum Benefit	\$2,000 per person	
Annual Deductible	\$60 Individual/\$240 Family	
Preventive Services	100% of the negotiated charge; not subject to the deductible	100% of R&C; not subject to the deductible
Basic Restorative Services (Such as fillings, extractions, root canals, periodontal procedures)	70% of the negotiated charge after deductible	70% of R&C after deductible
Major Restorative Services (Such as crowns, bridges, inlays, onlays)	50% of the negotiated charge after deductible	50% of R&C after deductible
Dental Oral Surgeries Simple extractions and other oral surgery procedures	70% of the negotiated charge after deductible	70% of R&C after deductible
Dental Oral Surgeries Complex surgical extractions (ADA Codes: 07220, 07230, 07240, 07241, 07951)	50% of the negotiated charge after deductible	50% of R&C after deductible
Prosthetic Repairs and Adjustments Denture adjustments and repairs, bridge repair	70% of the negotiated charge after deductible	70% of R&C after deductible
Prosthetics Dentures (full and partial), bridges, dental implants and covered implant-related services	50% of the negotiated charge after deductible	50% of R&C after deductible
Orthodontic Services for Enrolled Dependent Children up to age 26*	50% of the negotiated charge after deductible	50% of R&C after deductible
Lifetime Orthodontia Maximum Benefit	\$3,000 per person	
Lifetime TMJ Maximum Benefit**	\$500 per person	

* Treatment that began for a covered adult before January 1, 2017 is covered up to the \$3,000 lifetime orthodontia maximum benefit as long as the individual remains enrolled in the Comprehensive Dental Option.

** Amounts applied up to a covered person's TMJ maximum are included when determining when that person has met his or her annual maximum benefit.

How the MetLife Dental Options Work

How Much the Plan Pays

The plans classify different dental procedures as Preventive, Basic Restorative, Major Restorative and Orthodontic. A list of which procedures fall under each of these categories can be found in "What the MetLife Dental Options Cover" later in this section.

The percentage of a covered expense that the plan pays differs by the category of that expense. To learn the benefit levels that each dental option offers by category, refer to the coverage charts that appear earlier in this "Dental Benefits" section.

Under the Comprehensive Dental Option, you must satisfy the plan's deductible before benefits are paid for Basic Restorative, Major Restorative and Orthodontic covered expenses. You do not have to meet a deductible with the Basic Dental Option.

Deductibles

The deductible is the amount you, a covered dependent or your family has to pay each calendar year before the plan starts paying benefits.

You do not have to meet a deductible with the Basic Dental Option. Under the Comprehensive Dental Option, you, your covered dependent or your family need to meet a new deductible each calendar year. For specific deductible amounts, refer to the coverage charts that appear earlier in this "Dental Benefits" section.

The Comprehensive Dental Option has an individual and family deductible:

- The individual deductible is the amount you pay for each person's covered expenses each calendar year before the plan begins to make payment for that person's expenses (excluding any expenses that are not subject to the deductible)
- The family deductible is the maximum you pay in deductibles for yourself and all covered dependents. You pay the expenses for each covered dependent until that person's expenses reach the individual deductible amount. However, if the amount you pay toward deductibles for yourself and all covered dependents reaches the family deductible amount, you do not need to pay any more toward deductibles for the remainder of the calendar year

Some expenses do not count toward the deductibles:

- Expenses for Diagnostic and Preventive services
- Expenses above Reasonable and Customary (R&C) charges
- Dental care not covered by the plan

Meeting the Family Deductible

To determine when the family deductible has been met, combine the amounts used to meet the individual deductibles for covered family members. Keep in mind that no one person can contribute more than the individual deductible amount toward the family deductible.

Once the family deductible has been met, the plan starts paying benefits for every covered member of your family for the rest of that calendar year, at the applicable coinsurance rate.

Benefit Maximums

Some dental benefits and services are subject to maximums, as outlined here.

Annual Maximum Benefit

For each covered person, the dental plan has an annual maximum benefit for all covered expenses combined:

- Basic Dental Option: \$600
- Comprehensive Dental Option: \$2,000

Note that costs related to preventive visits and treatment of TMJ problems are included in the calculation that determines when the annual maximum benefit for each covered person has been met.

Lifetime Orthodontia Maximum Benefit

(Applies only to the Comprehensive Dental Option)

For covered orthodontic expenses, there is no annual maximum benefit. However, the Comprehensive Dental Option has a lifetime orthodontia maximum benefit of \$3,000 per person.

Benefits previously paid under another Delta Air Lines dental option for orthodontic services count in determining when the lifetime orthodontia maximum has been reached.

Amounts applied toward a covered person's orthodontia maximum do not count when determining whether a person has met his or her annual maximum benefit.

Orthodontic services are only covered for enrolled dependent children up to age 26. Please note that treatment that began for a covered adult before January 1, 2017 is covered up to the \$3,000 lifetime orthodontia maximum benefit as long as the individual remains enrolled in the Comprehensive Dental Option.

Lifetime TMJ Maximum Benefit

Covered treatment for temporomandibular joint (TMJ) problems are considered Basic Restorative services.

There is no annual maximum benefit for covered expenses for TMJ treatment. However, the plan pays no more than \$500 in a covered person's lifetime for covered TMJ expenses. Benefits previously paid for TMJ treatment under another Delta dental option count in determining when the lifetime TMJ maximum has been reached.

Amounts applied to a covered person's TMJ maximum count when determining when that person has met his or her annual maximum.

Pre-Treatment Estimates

Before you undergo any complex dental work such as crowns, bridges, dentures or periodontal work (typically, those services totaling more than \$300), you should talk to your dentist about getting a pre-treatment estimate from MetLife. In essence, requesting a pre-treatment estimate is like submitting a claim before you receive a dental service or procedure. It gives you important information about what services are covered and what level of benefits may be payable so that you can plan appropriately and talk to your dentist about alternate treatments, if necessary.

Your dentist can submit a request for a pre-treatment estimate online at www.metdental.com or by calling 877-MET-DDS9 (877-638-3379). This website and phone number are for dental professionals

only. For most procedures, you and your dentists will receive the pre-treatment estimate – online or by fax – during your dental appointment.

While the pre-treatment estimate will give you an idea of what your out-of-pocket costs will be, it is not a guarantee of payment for the benefits it describes. Actual benefit determinations are made when services are rendered and are subject to your plan eligibility and the dental option's provisions, such as applicable deductibles, plan maximums, and plan and frequency limitations.

Alternate Benefit

Your dental plan options provide that where two or more professionally acceptable dental treatments for a dental condition exist, your plans pay dental benefits for the least costly treatment alternative (called the "alternate benefit") if more than one method can provide professionally satisfactory results.

Generally, if you and your dentist have agreed on a treatment that is more costly than the alternate benefit, you must pay the additional cost.

For example, if a porcelain crown is performed on a molar tooth instead of a full cast crown (the alternate benefit), your out-of-pocket expense will be the difference between the plan benefits for the porcelain crown and the full cast crown.

Note: Amalgam and composite fillings are both professionally acceptable methods for filling a molar and are not subject to the alternate benefit provision. However, replacement of an existing amalgam filling with a composite filling is only covered when dentally necessary.

To avoid any misunderstandings, you should discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate prior to receiving certain high cost services such as crowns, bridges or dentures. Your dentist will receive an Explanation of Benefits (EOB) outlining your plans reimbursement for those services and your out-of-pocket expense.

Extended Dental Benefits When Coverage Ends

You or a covered family member might undergo dental work that is not complete until after your dental coverage ends. Your expenses related to this dental work may be covered only if they are for:

- **Installation of fixed bridgework and full or partial dentures:** The first impression must be taken and/or abutment of teeth fully prepared while you or your family member are covered. Also, the device must be installed or delivered to the individual within three calendar months after coverage ends
- **Installation of crowns, inlays or onlays:** The tooth must be prepared while you or your family member is covered. Also, the crown, inlay or onlay must be installed within three calendar months after coverage ends
- **Root canal therapy:** The pulp chamber of the tooth must be opened while you or your family member is covered. The treatment must be completed within three calendar months after coverage ends

There is no extension of benefits for any dental service that is not described above.

Questions?

- Call the MetLife Dental Customer Service Center at **855-700-7992**
- Visit **www.metlife.com/mybenefits**; type in the company name (“Delta Air Lines”)

The MyBenefits website can help you manage your dental plan. In addition to finding a participating dentist or specialist, you can:

- Review your plan information, including what’s covered and coinsurance
- Track your deductible and plan maximums
- View your claim history
- Read oral health information to help you make informed decisions about your care

What the MetLife Dental Options Cover

To be covered, dental care treatment, services and supplies must be necessary and customary as determined by the standards of generally accepted dental practice and provided by or under the direction of a licensed dentist. Covered dental charges include expenses for dental care and treatment resulting from a non-occupational disease, defect or accidental injury. To qualify as a covered charge, an expense must be all of the following:

- For services received while the person is covered by the dental plans
- Ordered by a licensed dentist, and
- Included in the description of covered dental services outlined on the following pages

Preventive and Diagnostic Services

Basic Dental Option and Comprehensive Dental Option

- Two oral examinations per calendar year
 - Routine cleanings (oral prophylaxis) — two per calendar year
 - Periodontal maintenance cleanings — two per calendar year following active periodontal therapy
- Note:** The number of covered oral prophylaxis cleanings and the number of covered periodontal maintenance cleanings cannot exceed four cleanings in a calendar year
- Fluoride treatment — one per calendar year for covered children under age 14
 - Bitewing images (X-rays) — one set per calendar year for all covered participants
 - Panoramic or full mouth radiographic images (X-rays) — one set every 36 months; includes panoramic and bitewing images completed in one visit (**not covered by the Basic Dental Option**)
 - Sealants — one topical application per permanent posterior (back) tooth in a three-year period for covered participants under age 19

Basic Restorative Services

Basic Dental Option and Comprehensive Dental Option

- Fillings — amalgam and composite
 - Note:** Replacement of an existing amalgam filling with a composite filling is only covered when dentally necessary
- Extractions
 - Note:** Complex surgical extractions are covered as Major Restorative Services rather than as Basic Restorative Services
- Apicoectomy
- Root canal treatment
- Periodontal services for treatment of tissue supporting the teeth
 - Crown lengthening
 - Gingivectomy or gingivoplasty
 - Note:** Separate reimbursement is not provided for a gingivectomy when performed in conjunction with the preparation of a crown or other restoration, by the same dentist/dental office. If performed by a non-participating dentist, the charge for the gingivectomy will be the patient's responsibility
 - Osseous Surgery and Osseous Graft – includes flap entry and closure. Coverage for osseous grafts includes single and multiple sites
 - Periodontal scaling and root planing (including gingivectomy)
- Crown build-up, cast post and core
- Administration of anesthesia, when necessary, as determined by MetLife under terms of generally accepted dental standards in connection with oral surgery, complex surgical extractions or other covered dental services
- Injections of antibiotic or chemotherapeutic drugs administered by the attending dentist before treatment
- Space maintainers for covered children under age 17
- Treatment of TMJ
- Re-mineralization
- Prosthetic repairs, relines and adjustments
- Repair or re-cementing of crowns, inlays or onlays, dentures or bridgework

Major Restorative Services

Comprehensive Dental Option Only

- Services needed to replace one or more natural teeth, including installation of fixed bridgework and partial or full removable dentures
- Replacement of temporary full denture by a new permanent full denture when the existing denture cannot be made permanent, and the permanent denture is installed within 12 months after the existing denture

- Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed
- Inlays, onlays, crown restorations, and prosthodontic services including partials, dentures, bridges, but not more than one such restoration to the same tooth surface within five years of the prior restoration
- Bite registrations, precision or semi-precision attachments
- Single tooth implant body, abutment and implant crown

Note: Replacement benefits for implant-related services are covered every five years

Oral Surgery

Comprehensive Dental Option Only

Some oral surgery is considered a medical expense, while other oral surgery is considered a dental expense. In some cases, charges are split between medical and dental benefits — meaning that some portions of the charge may be considered for payment under your dental option, while other portions may be considered under your medical option.

To determine whether your procedure is medical only, dental only or both, your dental provider should submit a pre-treatment estimate along with any diagnostic radiographic images (X-rays), materials and narratives to MetLife. You or your dental provider should also contact UHC by calling Delta Health Direct at **877-912-1820** to verify coverage as needed or submit a request for a predetermination of benefits.

Covered expenses paid by the plan for dental oral surgery do apply toward the annual dental maximum, and are paid at 70%, after you meet the annual dental deductible. **However, certain dental oral surgeries are covered at 50%.** Please call MetLife Dental Customer Service Center at **855-700-7992** to review which oral surgeries are covered and at what percentage charges are paid.

If your dental oral surgery requires any facility or facility-related charges, these are considered medical expenses by UHC (provided you are enrolled in a UHC-administered Delta medical option). If you are enrolled in a UHC-administered Delta medical option, all facility or related charges are paid under your medical plan at the appropriate Coinsurance level after you meet the Deductible.

Also, note that orthognathic surgery, dental services necessary because of accidental injury to sound natural teeth, and dental care required for the direct treatment of some limited medical conditions are considered medical expenses. For more information regarding dental services and oral surgeries covered as medical expenses, see “Dental Services Covered by This Medical Plan: Accident or Medical Condition Related”, “Orthognathic Surgery” and “Temporomandibular Joint Dysfunction (TMJ)” in the “Medical Benefits” section of this handbook.

HMO Participants Enrolled in the Comprehensive Dental Option

Some oral surgeries and expenses related to oral surgeries that are considered medical in nature may *not* be covered by an HMO. If you are in an HMO that does not cover oral surgery or related charges, you have no coverage for the oral surgery and/or related charges, and you are required to pay for 100% of the applicable charges. If you are planning an oral surgery, consult with your HMO and your dental plan administrator to see what is covered.

Orthodontia

Comprehensive Dental Option Only

Orthodontic benefits include expenses related to the prevention and correction of irregularities of the teeth and associated malocclusion (including simple extraction for orthodontic purposes).

The Comprehensive Dental Option pays 50% for covered orthodontic expenses after the plan's \$60 annual individual dental deductible has been met and up to the lifetime maximum benefit of \$3,000. If the treatment or payment plan extends into a second calendar year, a new \$60 annual deductible is applied. Orthodontic treatment is not covered in the Basic Dental Option.

Before you obtain services, your orthodontist should complete and submit to MetLife a pre-treatment estimate that includes the:

- Total case fee
- Date of banding
- Approximate length of time treatment is necessary
- Name of the provider

Benefit payments for covered full-banded orthodontic treatment up to the maximum benefit are made in quarterly installments. To determine your initial payment, MetLife estimates the entire cost of your treatment and applies 25% of the covered amount to the installation of the appliance. Subsequent payments are prorated over the estimated duration of the treatment.

If other orthodontic coverage exists for the patient, the amount paid by the Delta dental plan **will** be reduced by that amount.

Payments are made only for services performed while covered under the Delta dental plans.

Orthodontic services are only covered for enrolled dependent children up to age 26. Please note that treatment that began for a covered adult before January 1, 2017 is covered up to the \$3,000 lifetime orthodontia maximum benefit as long as the individual remains enrolled in the Comprehensive Dental Option.

What the Dental Options Do Not Cover

The dental options do not cover the following:

- Charges for treatment by a person other than a dentist, except for cleaning or scaling of teeth, which may be performed by a licensed hygienist, if such treatment is received under the supervision and direction of a dentist
- Charges for dental services that are not considered necessary in terms of generally accepted dental standards
- Amounts greater than the Reasonable and Customary (R&C) charge
- Separate services billed that are an integral part of the primary procedure performed, as the primary procedure is reimbursed only at an allowed amount. When such services are received from a non-participating provider, you will be responsible for charges for procedures that are billed separate from the primary procedure
- Expenses in excess of the cost of the least expensive professionally adequate restoration
- Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures

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- Charges for prosthetic devices (including bridges and crowns) and their fitting for individuals who became eligible for coverage after the device was installed
- Charges for prosthetic devices (including bridges and crowns) and their fitting that were ordered while the participant was not an eligible covered family member but were delivered or installed after the individual became a covered participant — or which were ordered while the individual was an eligible covered family member but are not installed or delivered to the individual until three or more calendar months after coverage terminated
- Replacement of an existing amalgam filling with a composite filling if not dentally necessary
- Charges for crowns, inlays/onlays, bridges, dental implants or other services if a less expensive restoration is determined to be professionally adequate
- Temporary procedures
- Crowns, veneers or onlays when done for cosmetic or aesthetic purposes
- Charges for the replacement of a lost or stolen prosthetic device
- Home fluoride
- Charges for infection control as a separate service
- Expenses for which the patient is not required to pay
- Fluoride treatment for children on or after reaching their 14th birthday
- Sealants for children on or after reaching their 19th birthday
- Space maintainers for children on or after reaching their 17th birthday
- Expenses related to occupational injury/disease
- Claims filed more than 12 months from the date of service
- Charges in excess of the annual maximum limit
- Charges in excess of the lifetime orthodontic maximum benefit limit (Comprehensive Dental Option only)
- Orthodontic services for participants other than dependent children under age 26
- Charges in excess of the TMJ lifetime maximum limit
- Under the Basic Dental Option, all major restorative services and procedures, all dental oral surgery, and all orthodontic services and procedures
- Charges for dental services or supplies that are included as covered medical services (such as orthognathic surgery, dental services necessary because of accidental injury to sound natural teeth, and dental care required for the direct treatment of some limited medical conditions) under the plans. If you have questions about whether a service is covered under medical or dental benefits, contact MetLife at **855-700-7992**

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- Expenses attributable, directly or indirectly, to an injury, illness or condition that is, or could be, the subject of a claim against a third party (or under an insurance policy or program) if:
 - MetLife or the plan's other agent is not notified in writing of any claim against a third party (or under an insurance policy or program), within 31 days of making the claim(s)
 - The participant does not complete any reimbursement agreement provided by MetLife or the plan's agent
 - The participant does not notify the third party (and/or the issuer of the insurance policy or program) that the Delta medical plan has a lien on any amounts payable by such third party (and/or under the insurance policy or program) to the extent covered expenses are paid by the Delta dental plans; and
 - The participant does not provide information requested about the claim to MetLife or the plan's agent
- Charges in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate Dental Specialty Society
- Consultations or office visits
- Charges in connection with screening of a patient to be seen by a dentist for diagnosis and/or assessment of a patient
- Charges for Maxillofacial MRI image capture, Maxillofacial ultrasound image capture and the interpretation of such diagnostic images; however, they may be covered under medical if needed as a result of traumatic injury, accidental dental, treatment of cancer or cleft lip/palate. Members may contact UHC or their medical carrier directly to inquire further
- Other expenses that are not listed but are excluded under MetLife guidelines

In addition, if a provider waives or forgives a member's copay or deductible, the amount considered for payment under the Plan will be the submitted amount, less the amount waived.

VISION BENEFITS

VISION BENEFITS

Vision care is an important part of any comprehensive benefits program. Caring for your eyes involves more than occasionally changing your eyeglass prescription — it also includes regular checkups that may alert you to vision issues that could turn into serious problems if left untreated.

Delta offers an insured vision plan administered by EyeMed Vision Care (EyeMed), a national provider of vision and eye care services, and underwritten by Fidelity Security Life Insurance Company.

About This Summary

If you enroll in vision coverage, you will be provided with an ID Card from EyeMed containing information about your benefits as well as a list of providers. For your convenience, a summary of vision benefits is included here; however, this document does not override or supersede the terms of the certificate of insurance.

Who Is Eligible

Eligibility for vision care benefits is determined by the same rules that apply to the Delta medical and dental benefits. Generally, eligible groups include:

- Active full-time and part-time regular employees
- Inactive regular employees
- Certain retirees and survivors

For details on eligibility, see the “Eligibility” section of this handbook.

Enrollment

You may enroll in Delta’s vision plan, and add or drop eligible dependents to your coverage, when you are hired or rehired, and during the annual open enrollment period. If you qualify to change your benefits because you have a qualified life event change, you may be eligible to change your vision coverage mid-year. See the “Life Events” section of this handbook for more details.

How the Plan Works

Your vision benefits from EyeMed cover eye examinations, frames, lenses and contact lenses. When you use an EyeMed network provider, you pay a Copay for most services and products. While you have the option to use an out-of-network vision care provider, your out-of-pocket costs will be higher. If you use an out-of-network provider, you must pay in full at the time of service and file a claim with EyeMed after your visit to receive reimbursement.

EyeMed Network Providers

Whether you prefer to shop for frames or contact lenses with an independent provider, at a retail chain or online, EyeMed offers a network of more than 91,000 participating providers at more than 25,000 locations, including LensCrafters®, Pearle Vision®, Target Optical®, Sears Optical® and many other favorite regional retailers like My Eye Dr., For Eyes and Stanton Optical. Additionally, in-network options like www.glasses.com, www.contactsdirect.com and www.LensCrafters.com allow for seamless benefit integration when purchasing online.

To find an EyeMed network provider:

- Visit **www.eyemedvisioncare.com**; click on Find a Provider and choose "Insight" for the network
- Call EyeMed at **833 DELTA VP (833-335-8287)** to hear details about your benefits, locate a provider, request an ID Card or reach customer service

How to Receive Services From a Network Provider

Using the program is easy:

- Call the network provider of your choice to schedule an appointment
- Identify yourself as an EyeMed member and Delta employee or covered dependent
- Give the provider's office the employee's first and last name, as well as the date of birth of any covered dependents needing services

The provider's office verifies your eligibility for services. No claim forms are required.

Receiving Non-Network Benefits

You receive the greatest value and maximize your benefit dollars if you select a provider who participates in the EyeMed network.

Even so, you may receive services from a non-network provider. If you choose a non-network provider, you must pay the provider directly for all charges and submit a claim for reimbursement to:

First American Administrators
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For a claim form, visit **www.eyemedvisioncare.com** or call **833 DELTA VP (833-335-8287)**.

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Key Features of the Vision Plan

Covered Expenses	Your In-Network Cost	Non-Network Reimbursement*
Eye Exam with Dilation as Necessary (one exam every 12 months)	\$10 Copay	Up to \$30
Retinal Imaging Benefit	Up to \$39	Not Covered
Contact Lens Fit and Follow-up (available once a comprehensive eye exam has been completed) <ul style="list-style-type: none"> Standard Contact Lens Premium Contact Lens 	\$0 Copay, paid in-full fit and 2 follow-up visits \$0 Copay, 10% off retail prices**, then apply \$55 allowance	Up to \$35 Up to \$35
Frames for Eyeglasses (one frame every 24 months)	\$0 Copay; \$150 allowance, 20% off balance** over \$150	Up to \$58
Standard Plastic Lenses (one pair of eyeglass lenses every 12 months in lieu of contact lenses) <ul style="list-style-type: none"> Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses Standard Progressive Lenses Premium Progressive Lenses 	\$15 Copay \$15 Copay \$15 Copay \$15 Copay \$65 Copay See Progressive Price List below	Up to \$25 Up to \$35 Up to \$46 Up to \$60 Up to \$39 Up to \$39
Lens Options (one pair of eyeglass lenses every 12 months in lieu of contact lenses) <ul style="list-style-type: none"> UV Treatment Tint (Solid and Gradient) Standard Plastic Scratch Coating Standard Polycarbonate Standard Anti-Reflective Coating Polarized Photochromatic/Transitions Plastic Premium Anti-Reflective Other Add-Ons 	\$12 Copay \$0 Copay \$0 Copay \$0 Copay \$35 Copay \$75 Copay \$65 Copay See Progressive Price List below 20% off retail price**	Up to \$3 Up to \$11 Up to \$11 Up to \$28 Up to \$7 Up to \$4 Up to \$7 Up to \$7 Not Covered
Elective Contact Lenses (every 12 months in lieu of eyeglass lenses) <ul style="list-style-type: none"> Conventional Disposable 	\$0 Copay; \$130 allowance, 15% off balance** over \$130 \$0 Copay; \$130 allowance, plus balance over \$130	Up to \$95 Up to \$95
Medically Necessary Contact Lenses	\$0 Copay, paid in full	Up to \$210

* Your non-network reimbursement will be the lesser of the listed amount or your actual cost from the non-network provider.

** Some states have approved legislation that allows managed care providers to not honor discounts (such as an additional percentage off of the balance) that are outside of the standard benefit. The provider locator will indicate if a specific provider has opted to not honor the additional discounts.

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Progressive Price List*

	Your In-Network Cost (Includes Lens Copay)
Premium Progressive Lens*	
• Tier 1	\$85 Copay
• Tier 2	\$95 Copay
• Tier 3	\$110 Copay
• Tier 4	\$65 Copay, 80% of charge less \$120 allowance
Premium Anti-Reflective Coating*	
• Tier 1	\$47 Copay
• Tier 2	\$58 Copay
• Tier 3	80% of charge

* Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. EyeMed Vision Care reserves the right to make changes to the products on each tier and your out-of-pocket costs.

Additional Discounts and Special Offers

Discounts for covered Delta participants may apply on laser vision correction (LASIK or PRK) from U.S. Laser Network, hearing health care from the Amplifon Hearing Network and on items not covered by the plan. However, some states have approved legislation that allows managed care providers to not honor discounts (such as an additional percentage off of the balance) that are outside of the standard benefit. The provider locator will indicate if a specific provider has opted to not honor the additional discounts.

Visit www.eyemedvisioncare.com/delta to locate providers that offer these additional discounts and for details. And, look for special offers, such as substantial savings on contact lenses when ordering online at www.contactsdirect.com.

What the Vision Plan Does Not Cover

Vision coverage does not include:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Any eye or vision examination, or any corrective eyewear required as a condition of employment; safety eyewear
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses and/or contact lenses
- Non-prescription sunglasses
- Two pair of glasses in lieu of bifocals
- Services rendered after the date you or a covered dependent cease to be covered under the policy, except when vision materials that were ordered before coverage ended are delivered, and the services rendered are within 31 days from the date of such order
- Services or materials provided by any other group benefit plan providing vision care
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available

Vision Plan Questions?

Call EyeMed at **833 DELTA VP (833-335-8287)** Monday - Saturday from 7:30 a.m. - 11:00 p.m. EST or Sunday from 11:00 a.m. - 8:00 p.m. EST.

COBRA CONTINUATION COVERAGE

COBRA CONTINUATION COVERAGE

This "COBRA Continuation Coverage" section includes important information about your right to COBRA continuation coverage, which is a temporary extension of certain healthcare coverage after you or your eligible dependents lose that coverage due to certain circumstances. COBRA continuation coverage is available for medical, dental, vision and Healthcare FSA coverage; it is not available for the Dependent Care FSA.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your dependents who are covered under the plans when you, your Spouse or eligible dependent children would otherwise lose health coverage under the plans.

This section explains COBRA continuation coverage, when it may become available to you, your Spouse and your eligible dependent children, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options outside the Delta health plans that may cost less than COBRA continuation coverage (see "Special Considerations When Deciding Whether to Elect COBRA" later in this "COBRA Continuation Coverage" section for more information).

COBRA is administered by Conduent HR Services LLC for Delta Air Lines (Conduent HR Services). You can reach Conduent HR Services by calling the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)**, Monday – Friday 8 a.m. - 5 p.m., Eastern time. International callers should dial **404-677-8000**. You also can reach Conduent HR Services at the following addresses:

For correspondence/questions only:

Delta Employee Service Center
P.O. Box 52045
Phoenix, AZ 85072

For COBRA Premium payments only:

Conduent HR Services LLC for Delta Air Lines
P.O. Box 382119
Pittsburgh, PA 15251-8119

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

COBRA Eligibility

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event occurs and any required notice of that event is properly provided, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your Spouse and your dependent children could become qualified beneficiaries if coverage under the plans is lost because of a qualifying event.

Under the plans, individuals who elect COBRA continuation coverage must pay the full cost of that coverage.

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If you are an employee, you will become a qualified beneficiary if you lose coverage under the plans because either one of the following qualifying events occur:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plans because any of the following qualifying events occur:

- Your Spouse dies
- Your Spouse's hours of employment are reduced
- Your Spouse's employment ends for any reason other than his or her gross misconduct
- You become divorced from your Spouse

Note: If an employee drops his or her Spouse from coverage during an enrollment period in anticipation of a divorce, and a divorce later occurs, then the divorce will still be considered a qualifying event, even though the Spouse lost coverage earlier. If the ESC is notified within 60 days after the divorce and the Spouse or employee can establish that the coverage was eliminated earlier in anticipation of the divorce, then COBRA continuation coverage may be available for up to 36 months after the divorce

Your dependent children (including children participating under a Qualified Medical Child Support Order) will become eligible for COBRA election rights if they lose coverage under the plans because any of the following qualifying events occur:

- Parent-employee dies
- Parent-employee's hours of employment are reduced
- Parent-employee's employment ends for any reason other than his or her gross misconduct
- Parents become divorced
- Child stops being eligible for coverage under the plans as a dependent child (e.g., reaches the maximum age of 26)

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed by your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the plans, the retired employee will become a qualified beneficiary. The retired employee's Spouse, surviving Spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plans.

Notification of Qualifying Events

COBRA continuation coverage will be offered to qualified beneficiaries only after the plans are notified that a qualifying event has occurred. When the qualifying event is the end of your employment, your reduction of hours, the employee's death, or commencement of a proceeding in bankruptcy with respect to the employer, the notification to the plans is automatic and no action is required by you or your dependents.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or a dependent child's losing eligibility for coverage), you, your Spouse or dependent child must notify the ESC within 60 days after the qualifying event occurs.

Depending on the type of qualifying event, notice of the event may be made online through Benefits Direct, which is located on the Self Service site of Deltanet, or by submitting the proper Family Status Change Form (along with any required supporting documentation). See "How to Report a Life Event" in the "Life Events" section of this handbook for details on how to report a qualifying life event. Verbal notice, including notice by telephone, is not sufficient.

No matter which notification method is used, you must notify the ESC within 60 days after the later of:

- The date of the qualifying event, or
- The date on which you lose, or would lose, coverage under the terms of the plans as a result of the qualifying event

You, your Spouse or your dependent child must provide notice in a timely manner. If you, your Spouse or dependent child fails to provide notice to the ESC during this 60-day notice period, you and your family members who lose coverage due to the qualifying event will not be offered the option to elect COBRA continuation coverage.

Note that a child born to, adopted by or placed for adoption with a participant during a period of COBRA continuation coverage is eligible for coverage as a qualified beneficiary. However, you must notify the ESC within 60 days of the child's birth, adoption or placement for adoption with the participant.

Life events that qualify you or your eligible dependents for COBRA continuation coverage must be reported to the ESC within 60 days, as noted above. Please see the "Life Events" section in this handbook for details about reporting life events.

Electing COBRA Continuation Coverage

Once the ESC is informed that the qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their covered children.

- The following information will be provided to qualified beneficiaries at the time of the qualifying event — as long as timely notice of such event was received by the Delta ESC:
 - The ESC sends you a Notice of Right to Elect COBRA Continuation Coverage letter informing you that you have 60 days to enroll for COBRA benefits
 - In addition to the notice described above the ESC sends you a COBRA qualifying event package that reflects your healthcare coverage options in effect at the time your coverage was terminated

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- Note that the Enrollment Worksheet in your COBRA qualifying event package will show all healthcare coverage options available to you, including the healthcare coverage options that you were enrolled in before your qualifying event. You may elect COBRA continuation coverage under a different medical and/or dental option available under the plans, or the same option that you were enrolled in before your qualifying event. However, if you were not enrolled in a particular benefit type (for example, medical, dental, etc.) before your qualifying event, you will not be offered COBRA continuation coverage for that benefit. For example, if you were not enrolled in vision coverage before your qualifying event, you will not be eligible to add vision coverage through COBRA
- If you decide to elect COBRA continuation coverage, your election must be made by the election rights expiration date shown on your COBRA Enrollment Worksheet. This date is either 60 days from the date coverage was lost, or if later, 60 days from the date the package is postmarked
- If you want to enroll for COBRA continuation coverage, you have 60 days to enroll online through Benefits Direct (which is located on the Self Service site of Deltanet) or by calling the ESC
- If you, your Spouse and/or any other qualified beneficiary do not submit completed COBRA elections by the deadline, you, your Spouse or the qualified beneficiary will permanently lose the right to elect COBRA continuation coverage
- Once your COBRA elections have been processed, the ESC will send you your first COBRA invoice
- Conduent HR Services will post your Premium payment within 30 days after you send it
- Note that any amounts accumulated toward annual Deductibles and the Out-of-Pocket Maximum before your coverage ends are maintained under COBRA coverage, even if you elect a different option under COBRA. For example, if you are enrolled in the Gold HSA Medical Option prior to your qualifying event and elect the Gold HSA Medical Option or other medical option for COBRA coverage, the claims used to accumulate your year-to-date Deductible and Out-of-Pocket Maximum will not reset to zero. Claim amounts will continue to accumulate toward the Deductible and Out-of-Pocket Maximum through the end of that calendar year or until you cease COBRA coverage, whichever comes first

How to Enroll

To access Benefits Direct, go online to **<https://deltanet.delta.com>**. You can use any computer with Internet access. You will need a valid Delta Passport password. (If you can access TravelNet or if you have home access to Deltanet, you have a valid Passport password.)

You also can log on directly to Benefits Direct (for example, if you don't have a valid Delta Passport password) at **www.benefitsweb.com/delta.html**.

If you have questions about online enrollment, or if you experience difficulty enrolling, contact the ESC at **1-800 MY DELTA (1-800-693-3582)** Monday through Friday, 8 a.m. to 5 p.m. Eastern time. International callers should dial **404-677-8000**.

Adding Dependents After COBRA Coverage Begins

If you are a covered employee who has elected to continue coverage through COBRA, you may add a new Spouse, newborn or adopted child to your COBRA coverage, provided you do so within 60 days of the marriage, birth, adoption or placement for adoption and pay the required Premium. If notification to Delta or the ESC of the qualifying life event occurs after the 60-day window, you will have an opportunity to add this and other eligible family members who meet the plan's eligibility requirements during the next COBRA annual open enrollment period (provided you continue to be eligible for COBRA continuation coverage). Benefits elected during the annual open enrollment period will be effective January 1 of the next year.

When COBRA Coverage Begins

For each qualified beneficiary who elects COBRA continuation coverage within the required timeframe, and makes payment of required Premiums (as described below) by the deadlines for receipt, your elected coverage becomes retroactively effective to the date when you lost coverage. You do not experience a gap in coverage when transitioning from active to COBRA continuation coverage.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage that lasts up to a specified number of months, depending on the type of qualifying event experienced. If timely payment for COBRA continuation coverage is made, and the qualifying event is:

- The death of the employee, your divorce, or a dependent child losing eligibility, then COBRA continuation coverage can last up to a total of 36 months
- The end of employment or reduction of the employee's hours of employment, then COBRA continuation coverage generally lasts up to a total of 18 months
- The end of employment or reduction of the employee's hours of employment, and the covered employee became entitled to Medicare benefits fewer than 18 months before the qualifying event, then COBRA continuation coverage for qualified beneficiaries (other than the employee) can last up to 36 months after the date of Medicare entitlement

Example: Rosa becomes entitled to Medicare benefits eight months before her employment termination date. Rosa will be eligible for COBRA continuation coverage for a maximum period of 18 months. However, COBRA continuation coverage for Rosa's husband and daughter can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months of COBRA continuation coverage after Rosa's last day of work (36 months minus eight months).

- Substantial reduction in coverages within a year either before or after filing of a bankruptcy petition under Chapter 11, then COBRA continuation coverage can last for the lifetime of the retiree or survivor or 36 months for the retiree's spouse and/or eligible dependents following the death of the retiree

Extension of Coverage

If the maximum period of COBRA continuation coverage you are eligible for is 18 months, there are two ways in which this 18-month period can be extended. If the maximum period of COBRA continuation coverage you are eligible for is 36 months, no extensions are available.

Second Qualifying Events

If any of your family members who are qualified beneficiaries (your Spouse and/or dependent children only) experience another qualifying event during the 18 months of COBRA continuation coverage, they may elect to extend the period of COBRA continuation coverage for an additional 18 months, up to a maximum total period of 36 months, if notice of the second qualifying event is timely given to the ESC.

Such second qualifying events may include the death of a covered employee, divorce, or if a dependent child stops being eligible for coverage as a dependent under the plans. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plans if the first qualifying event had not occurred.

You must notify the ESC in writing within 60 days after a second qualifying event occurs if you want to extend your COBRA continuation coverage.

Disability Extension Under COBRA

If you or anyone in your family who is a qualified beneficiary covered under the plans is determined by the Social Security Administration (SSA) to be disabled and you notify the ESC in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum total period of 29 months.

To be eligible for this extension, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them qualifies.

You must notify the ESC in writing that a qualified beneficiary has been determined by the SSA to be disabled. This notice must be furnished on a date that is both within 60 days after the disability determination is issued and before the end of the original 18 months of COBRA continuation coverage. A copy of the SSA's official disability determination, showing the date of such award, must accompany the qualified beneficiary's notice to the ESC.

If the qualified beneficiary is determined by the SSA to no longer be disabled, you or the affected qualified beneficiary must notify the ESC in writing of that fact within 60 days of the SSA's determination. If you do not timely notify the ESC, your coverage will still be discontinued as of the date of the SSA's determination, and all claims made for the period thereafter will be denied.

Cost of COBRA Continuation Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary is required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Initial Payment for COBRA

If you or a qualified beneficiary elects COBRA continuation coverage, you or the qualified beneficiary does not have to send any payment at the time of your election. However, you or the qualified beneficiary must make the first payment for COBRA continuation coverage no later than 45 days after the date of the election.

COBRA continuation coverage will not start until Conduent HR Services has timely received the initial Premium payment. If you or a qualified beneficiary does not make the first payment for COBRA continuation coverage in full within 45 days after the date of the election, then you or the qualified beneficiary will lose all COBRA continuation coverage rights under the plans.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the plans would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the ESC at **1-800 MY DELTA (1-800-693-3582)** to confirm the correct amount of the first payment.

Send the first payment — and all payments that follow — for COBRA continuation coverage to:

Conduent HR Services LLC for Delta Air Lines
P.O. Box 382119
Pittsburgh, PA 15251-8119

Periodic Payments for COBRA

After you or a qualified beneficiary makes the first payment for COBRA continuation coverage, you or the qualified beneficiary is required to make monthly payments for each subsequent month of coverage. The amount due for each qualified beneficiary will be shown in the election package you receive from the ESC.

Payments must be made on a monthly basis. Each month's payment for continued coverage is due on the 1st day of each month for the coverage period. You will be mailed a monthly invoice from the ESC around the middle of each month. Be sure that your Premium payments are postmarked by the first day of each month. If Conduent HR Services receives the Premium payment on or before the first day of the month to which it applies, coverage under the plans continues for that month without any break in coverage.

Grace Period for Periodic Payments

Although monthly payments are due on the first of each month, you or a qualified beneficiary will be given a grace period of 30 days after the first day of the month to make each periodic payment. COBRA continuation coverage is provided for each month as long as payment for that month is made before the end of that payment's grace period. If you or the qualified beneficiary fails to make a periodic payment before the end of the grace period for that month, the following month's bill shows the outstanding balance for the previous month in addition to the current month's Premium.

If a Premium payment is submitted after the due date, but within the grace period (based on the postmark date), the payment is accepted and credited to your or the qualified beneficiary's account; however, your coverage under the plans will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If the payment is submitted after the grace period expiration date (based on the postmark date), the payment is refunded to you or the qualified beneficiary, coverage is canceled and a termination of COBRA continuation coverage letter is sent. **If COBRA continuation coverage is canceled for nonpayment, coverage cannot be reinstated, and you, your Spouse or dependent child have no further rights to COBRA continuation coverage.**

Benefit administrators (medical, dental, vision and/or Healthcare FSA, as applicable) will be notified that coverage is terminated as of the last day for which Premium payments were received.

When an insignificant shortfall (which is defined as the lesser of \$50 or 10% of the total monthly COBRA Premium) occurs and the balance is not paid in full, the partial payment cannot be posted as payment. For example, your Premium payment for the period of April 1-30 has an insignificant shortfall. You are sent a bill for the shortfall and given 30 days to make that payment (per the grace period procedure described above). If payment is not postmarked by the grace period deadline, your coverage is canceled as of March 31 and the Premiums that you had paid for April are returned to you.

COBRA Coverage Under the Healthcare FSA

If you are eligible for and participating in the Healthcare FSA and become ineligible for participation due to a qualifying event (for example, the termination of your employment with Delta or when going on an unpaid leave of absence — this can occur if your disability benefits from the Delta Pilots Disability and Survivorship Plan or Delta Family-Care Disability or Survivorship Plan cease and you move to an unpaid leave of absence), coverage is available to you through COBRA so you can continue to participate in the Healthcare FSA. You may continue your Healthcare FSA under COBRA continuation coverage *only* until the end of the calendar year in which the qualifying event occurred. You must pay the full cost of this continued coverage (your payroll deduction amount in effect before your qualifying event date), plus a 2% administrative fee.

Electing COBRA continuation coverage for your Healthcare FSA enables you or your eligible dependents to extend the time period for which claims for reimbursement may be incurred. Normally, to be eligible for reimbursement, a claim must be incurred while you are covered under and contributing to the Healthcare FSA. If you have not incurred enough expenses at the time of your qualifying event to recover your contributions to the Healthcare FSA, then you should consider electing COBRA continuation coverage. If elected, you may extend the coverage period long enough to incur claims that allow for full reimbursement of the pre-tax dollars (plus the new after-tax COBRA dollars) credited to your Healthcare FSA as of the qualifying event, but not past the end of the year.

As long as you continue to pay monthly COBRA Premiums, you may submit for reimbursement any eligible Healthcare FSA expenses incurred during the COBRA continuation coverage period. However, if you let your Healthcare FSA coverage lapse by either not electing to keep the account through COBRA or failing to make timely contributions, you may not receive reimbursement from the Healthcare FSA for any expenses incurred while you were not contributing, and thus not participating, in the Healthcare FSA.

When COBRA Coverage Ends

Generally, COBRA continuation coverage ends on the last day of the maximum coverage period (18, 29 or 36 months). COBRA continuation coverage for a Healthcare FSA will extend only to the end of the calendar year in which the qualifying event occurs. COBRA continuation coverage will be terminated before the end of the maximum coverage period if:

- Coverage is voluntarily canceled by contacting the ESC
- Any required Premium is not paid on time, as described above
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan
- A qualified beneficiary becomes entitled to Medicare benefits (including Part A, Part B or both) after electing COBRA continuation coverage
- Delta no longer provides group health coverage to any employees

COBRA coverage also may be terminated for any reason the plans would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud). In addition, COBRA continuation coverage also may be terminated if a qualified beneficiary recovers from a disability that extended COBRA continuation coverage. (For information about Delta's disability coverage, refer to the Disability Benefit Handbooks for your employee group on the Health & Insurance site located on Employee Connection.)

Once COBRA coverage is canceled, it cannot be reinstated.

Manage Your COBRA Coverage

Log on to Benefits Direct (on Deltanet at <https://deltanet.delta.com>, or, if you don't have a valid Delta Passport password, directly at www.benefitsweb.com/delta.html) to:

- Elect COBRA continuation coverage
- Add/drop dependents
- Update your address (certain participants only)
- View coverage documents and print forms
- View the status of your account
- Look up payment dates and amounts
- Change payment methods and make one-time direct debit payments

Or, call the ESC at **1-800 MY DELTA (1-800-693-3582)**.

Special Considerations When Deciding Whether to Elect COBRA

When you lose group health coverage, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan options (such as a spouse's plan). Some of these options may cost less than COBRA continuation coverage.

Through the Marketplace, you may be eligible to buy an individual plan. By enrolling in coverage through the Marketplace, you may qualify for federal subsidies that lower costs of your monthly premium. You can also check to see if lower deductible and out-of-pocket costs are available before you make an enrollment decision. You are responsible for researching what is available through the Marketplace, Medicaid or other group health plans available to you and deciding what is best for you. Being eligible for COBRA does not limit your eligibility for coverage through the Marketplace. However, enrolling in COBRA does disqualify you from receiving the federal subsidies and dropping coverage mid-year does not qualify you for a special enrollment period through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov.

You also should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of a qualifying event described above. You also will have the same special enrollment right at the end of COBRA continuation coverage if you keep COBRA continuation coverage in effect for the maximum time available to you.

When considering your options under COBRA continuation coverage, a Marketplace plan or other health coverage...

You should investigate and understand the following:

- ◆ **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA continuation coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive
- ◆ **Provider Networks:** If you're currently receiving care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage
- ◆ **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage
- ◆ **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations
- ◆ **Other Cost-Sharing:** In addition to Premiums or contributions for health coverage, you probably pay Copayments, Annual Deductibles, Coinsurance or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly Premiums, but a much higher Annual Deductible and higher Copayments

Special “Trade Act” Rules Concerning Tax Credit for COBRA Continuation Coverage

The Trade Preferences Extension Act of 2015 (the “Act”) retroactively reinstated, extended, and modified the Health Coverage Tax Credit (“HCTC”) from 2014 to December 31, 2019 for certain individuals who become eligible for trade adjustment assistance, and for certain retired employees who receive pension payments from the Pension Benefit Guaranty Corporation (PBGC) (“eligible individuals”). Under these tax provisions, eligible individuals can take a tax credit of 72.5% of Premiums paid for qualified health insurance, including COBRA continuation coverage. More information, including information on who to contact if you have questions, will be provided when it is available.

COBRA Rights

During the annual open enrollment period, you and any qualified beneficiaries have the same rights as similarly situated non-COBRA beneficiaries, with the exception of the right to continue participation in the Healthcare FSA. This includes the right to change medical options under the plans. To protect your and your family’s rights, you should keep the ESC informed of any changes to your or a family member’s home address. For your records, you also should keep a copy of any notices you send the ESC.

Questions About Your Rights?

If you have questions concerning your COBRA continuation coverage rights, call the ESC at **1-800 MY DELTA (1-800-693-3582)**.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at **www.dol.gov/ebsa** or call their toll-free number at **1-866-444-3272**. For more information about health insurance options available through the Health Insurance Marketplace, visit **www.healthcare.gov**.

CLAIMS INFORMATION & APPEALS

CLAIMS INFORMATION & APPEALS

This “Claims Information & Appeals” section is divided into two parts. The first part describes the claims review and appeal procedures applicable to all healthcare benefits available under the plans, except the medical HMO benefits and vision coverage through EyeMed Vision Care. The second part describes the claims review and appeal procedures for such excluded coverages and the Dependent Care Flexible Spending Account (FSA), as well as other procedures for resolving issues involving COBRA continuation coverage and Direct Bill (Premium Pay) disputes.

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the “Terms to Know” section at the end of this handbook for definitions.

Part 1 – ERISA Claims and Appeals Procedures

Filing Initial Claims

If you are enrolled in any of the plans outlined in this handbook, you may need to submit a claim to receive benefits under the plans. Information about filing specific types of claims and the time frames within which you must submit the claims appears below. When you submit any healthcare claim, it should be accompanied by a completed claim form as well as any required supporting documentation, such as itemized bills. Be sure to make copies of all completed claim forms and any accompanying supporting documentation for your records.

Once a claim is timely received, the appropriate claims administrator will provide you with a response — an Explanation of Benefits (EOB) or Health Statement — and, if appropriate, reimbursement within the time frames set forth below. Typically, benefits are paid as soon as the claims administrator receives the proof needed to support your claim. If you already have paid for services, benefits are usually payable directly to you; however, benefit payments for hospital services are generally paid directly to the hospital. At your request, the claims administrator may pay benefits directly to the provider of services. Note that some claims administrators may not be able to pay benefits directly to Non-Network Providers (providers not in the administrator’s network of physicians or dentists).

Authorized Representative

You may authorize an individual to act on your behalf in pursuing a claim or appeal. This individual is known as an “authorized representative.” For information about how to designate an authorized representative, contact the appropriate claims administrator. For claims administrator information, see the charts at the end of this “Claims Information & Appeals” section of the handbook.

Deadlines for Filing Claims

All MetLife dental claims and non-network medical, prescription drug, behavioral health/substance abuse claims must be submitted to the appropriate claims administrator within 12 months of the date of service, with the exception of the Puerto Rico Out-of-Area Medical Option, which has a two-year claim filing deadline.

Healthcare FSA claims must be submitted by March 31 for Eligible Expenses incurred during the prior calendar year.

When you file healthcare benefit claims, keep in mind that the charges are incurred on the date that the care, services or supplies are rendered or furnished — not the date on which they are billed.

Medical and Prescription Drug Claims

UnitedHealthcare (UHC) is the claims administrator for medical and prescription drug benefits for the medical options available under the Delta Account-Based Healthcare Plan (DABHP).

When you obtain medical treatment from a UHC Network Provider, present your UHC identification (ID) card when receiving services, and the provider will submit your claim for you automatically. Payment of your claim will be made directly to the provider.

When you obtain medical treatment from a Non-Network Provider, in most cases, you will be required to pay for your medical care at the time you are treated. In order to receive benefits from the DABHP, you must submit your medical claim to UHC.

The DABHP medical options only cover prescription drugs obtained from network pharmacies. When you obtain a prescription from a network pharmacy, present your UHC ID card, and the pharmacy will submit your claim for you automatically. In most instances, you do not need to submit a prescription drug claim to UHC for reimbursement. If you use a non-network pharmacy, you will need to pay for the entire retail cost of the prescription at the time of purchase.

If you are unable to provide your UHC ID card or identification number when you obtain a Covered Service, medical treatment or a prescription at a participating pharmacy, you may be required to pay for that service or prescription in full and submit a claim to UHC for benefits.

You may obtain a medical and/or prescription drug claim form online at **myuhc.com** or on Benefits Direct through Deltanet. If you have questions about the claims filing process for a medical or prescription drug claim, contact UHC by calling Delta Health Direct at **877-912-1820**.

Behavioral Health and Substance Abuse Claims

UnitedHealthcare (UHC)/OptumHealth Behavioral Solutions is the claims administrator for behavioral health and substance abuse (BH/SA) benefits for the medical options available under the DABHP.

When you obtain behavioral health or substance abuse treatment from a Network Provider, present your UHC identification (ID) card when receiving services and the provider will submit your claim for you automatically. Payment of your claim will be made directly to the provider.

When you obtain medical treatment from a Non-Network Provider, in most cases, you will be required to pay for your medical care at the time you are treated. In order to receive benefits from the DABHP, you must submit your medical claim to UHC/OptumHealth Behavioral Solutions.

If you are unable to provide your UHC ID card or identification number when you obtain a behavioral health or substance abuse Covered Service or treatment, you may be required to pay for that service or treatment in full and submit a claim to UHC/OptumHealth Behavioral Solutions for benefits.

You may obtain a medical/behavioral health claim form online at myuhc.com or on Benefits Direct through Deltanet. If you have questions about the claims filing process for a behavioral health or substance abuse claim, contact UHC/OptumHealth Behavioral Solutions at **800-533-6939**.

Dental Claims – Metropolitan Life Insurance Company (MetLife)

Metropolitan Life Insurance Company (MetLife) is the claims administrator for the dental options available under the DABHP.

If you use a dentist who is a MetLife PDP Plus network participating dentist, the dentist will submit claims for you.

If your dentist is not a MetLife PDP Plus network participating dentist, he/she also can submit claims to MetLife for payment. Claim reimbursement will be issued to the non-participating dentist for covered services. You will be responsible for any additional payment owed to the non-participating dentist. Non-participating dentists are not required to file your claim with MetLife, so it may be your responsibility to pay the non-participating dentist and file a claim for reimbursement. You may obtain a dental claim form online at www.metlife.com/mybenefits and type in the company name ("Delta Air Lines"). If you have questions about the claims filing process for a dental claim, contact MetLife at **855-700-7992**.

Healthcare FSA Claims

UnitedHealthcare (UHC) is the claims administrator for Healthcare Flexible Spending Account (FSA) benefits. You will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your Healthcare FSA for the Eligible Expenses that have been incurred. You may submit Healthcare FSA claims for reimbursement at any time during the plan year.

- Healthcare FSA expenses must be incurred between January 1 (or your date of hire, or date of enrollment, if later) and December 31 of the plan year (or your termination date, or date of discontinuance of participation, if earlier) to be eligible for reimbursement. If you begin participating in the Healthcare FSA partway through the calendar year, you may only be reimbursed for Eligible Expenses that you incur from the date you begin participating through December 31 of the plan year
- You have until March 31 of the following calendar year to submit your claim

To download a claim form for reimbursement for your Healthcare FSA, visit **myuhc.com** or search for the FSA claim form on Deltanet. If you do not have access to the Internet, contact the ESC at **1-800 MY DELTA (1-800-693-3582)** for assistance.

For other methods that you may elect and use for submitting claims to UHC, see the "Flexible Spending Accounts" section of this handbook for complete details.

FSA Claims Payment

Your payment comes to you in one of three ways:

- ◆ The approved amount of your FSA claim is mailed to you in the form of a check. Checks are mailed bi-weekly
- ◆ If you have elected Electronic Funds Transfer (EFT), the approved amount is deposited directly into your checking or savings account
- ◆ Your claim goes directly to the claims administrator for approval if you have elected the FSA Automatic Payment Option, and the approved amount comes to you in a check or is directly deposited

You can sign up for EFT or the Automatic Payment Option on **myuhc.com**. Remember, your entire Limited Purpose Healthcare FSA or Full Purpose Healthcare FSA allocation is available to you on the first day that you participate in the plan.

To help you maintain your records, your reimbursement check is accompanied by an explanation of each reimbursement and a statement of how much money remains in your account. You may view your explanation of benefits on **myuhc.com**.

Notice of Benefit Determination

After your claim is reviewed, the applicable claims administrator will provide you with a notice of its benefit determination within the time frames specified on the following pages. For urgent care and pre-service claims, you will receive a notice of benefit determination whether or not your claim is denied. For post-service and concurrent care claims, you are entitled to a notice if the claims administrator denies or makes an adverse determination on your claim for benefits.

The time frames for providing notice of a benefit determination generally start when a claim for benefits is received by the claims administrator. Notice of a benefit determination may be provided by mail or electronic delivery. However, as described on the following pages, in some urgent cases, oral notification is permitted. Note, that the reference to "days" below means calendar (not business) days.

Time Frames for Responding to Claims

Urgent Care Claims

Once an urgent care claim is submitted, the applicable claims administrator will notify you of its decision on your claim — whether it is approved or denied — as soon as possible but no later than 72 hours after receipt of the claim, unless the claim was incomplete or improperly filed. This notification may be made to you orally, followed up by a written or electronic notification of the decision within three days of the oral notification. For the medical options, the claims administrator and individual responsible for making benefit determinations will defer to the patient's attending provider determination as to whether a claim constitutes urgent care.

If your claim is incomplete, the claims administrator must notify you of this, in writing or by phone, and inform you what information is necessary to properly complete your claim. The claims administrator will do this as soon as possible, following receipt of your incomplete claim, but no later than 24 hours after such receipt.

If additional information is required, you will have a reasonable amount of time to provide the information, taking into account the circumstances, but not less than 48 hours. The claims administrator will notify you of its decision as soon as possible, but no later than 48 hours after the earlier of its receipt of the requested information or the period given to you to provide the requested information. The claims administrator may provide you with notification of its decision orally, but must follow up with a written or electronic notification within three days after the oral notification.

In addition, if your claim is not filed in accordance with these claims procedures, the claims administrator will notify you of this and the procedures that must be followed as soon as possible, but no later than 24 hours after receipt of the claim. This notification can be made orally, unless you request written notification.

Pre-Service Claims

Once a pre-service claim is submitted, the applicable claims administrator will notify you of its decision on your claim — whether it is approved or denied — as soon as possible, but no later than 15 days after receipt of the claim. This period may be extended by 15 days if the claims administrator determines, due to reasons beyond its control, that it needs extra time to process your claim. If the claims administrator needs additional time, it will notify you before the expiration of the initial 15-day period of the reasons for the extension and the date it expects to make its decision.

If an extension is needed because the claims administrator needs additional information from you to make its decision, the extension notice will describe the required information. In such case, you will have at least 45 days from the receipt of the notice to provide the requested information. The claims administrator's extension period will begin when you respond to the request for additional information (or upon the expiration of the 45 days given to you to make such response). The claims administrator will then notify you of its decision within 15 days of the earlier of your response or the expiration of the 45-day period.

In addition, if your claim is not filed in accordance with these claims procedures, the claims administrator will notify you of this and the procedures that must be followed as soon as possible, but no later than five days after receipt of the claim. This notification can be made orally, unless you request written notification.

Post-Service Claims

Once a post-service claim is submitted, the applicable claims administrator will notify you of its decision to deny your claim as soon as possible, but no later than 30 days after receipt of the claim. This period may be extended by 15 days if the claims administrator determines, due to reasons beyond its control, that it needs extra time to process your claim. If the claims administrator needs additional time, it will notify you before the expiration of the initial 30-day period of the reasons for the extension and the date it expects to make its decision.

If an extension is needed because the claims administrator needs additional information from you to make its decision, the extension notice will describe the required information. In such case, you will have at least 45 days from the receipt of the notice to provide the requested information. The claims administrator's extension period will begin when you respond to the request for additional information (or upon the expiration of the 45 days given to you to make such response). The claims administrator will then notify you of its decision within 15 days of the earlier of your response or the expiration of the 45-day period.

Concurrent Care Decisions

If a claim is made to extend a previously approved concurrent care decision, the claim will be decided within the same time periods as any other pre-service, urgent care or post-service claim. However, if the claim involves extending a concurrent care decision involving urgent care, and the claim is made at least 24 hours before the end of the approved period of time or number of treatments, the claims administrator must decide the claim within 24 hours after its receipt of the claim.

If a reduction or termination of any course of treatment is made before the end of the previously-approved time period or number of treatments, this is considered a denial of benefits. In such case, the claims administrator must notify you of this denial in advance of the termination or reduction to allow you time to appeal this decision before the reduction or termination occurs.

If Your Claim Is Denied

If your claim for healthcare benefits is denied, in whole or in part, the applicable claims administrator will provide you with notice of its decision, including:

- The specific reason or reasons for the denial of the claim
- Reference to the specific plan provision(s) on which the denial is based
- A description of any materials or information necessary for your claim to be approved, and an explanation of why such materials or information is necessary
- A description of the plans' claim review procedures and the time limits under those procedures, including a statement regarding your right to file a civil action under Section 502(a) of ERISA following a denial of your appeal(s)
- If applicable, a copy of the internal rule, guideline or protocol, or similar criterion that was relied on in making the claim determination
- If the denial is based on an exclusion for medical necessity or experimental treatment or similar exclusion limitation, a statement explaining the scientific or clinical judgment relied on in making the claim determination
- In the case of an urgent care claim, a description of the expedited review process applicable to such claims

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Additionally, for healthcare benefit claims (other than dental claims), the claims administrator also will provide you with:

- Information sufficient to identify the claim involved, including the date of the service, the health care provider and the claim amount (if applicable)
- A statement that you may request and receive the diagnosis treatment codes and their meaning
- A description of the standard, if any, that was used in denying the claim
- A description of available internal appeals and external review processes, including how to initiate an appeal
- Contact information for the applicable office of health insurance consumer assistance or ombudsman who may assist you with internal and external claims and appeals

Informal Claims Inquiries

If you are not satisfied with a medical, behavioral health/substance abuse or prescription drug benefit determination, or if you have questions about the determination, you may contact UHC by calling Delta Health Direct at **877-912-1820**, or you may call OptumHealth Behavioral Solutions directly, at **800-533-6939**.

Member Service representatives generally are available Monday through Friday between 8 a.m. and 8 p.m. from the time zone you are calling from (may not apply if you are in a non-US time zone). If the Member Services representative is unable to resolve your issue during your telephone conversation, you may initiate the formal claims appeal procedure by putting your conversation — along with supporting documentation — in writing.

Complex Claims Assistance Through Health Advocate, Inc.

Health Advocate, Inc. is an independent third-party service that can help Delta health plan participants in appealing certain clinically-based medical or behavioral health/substance abuse claims that have been denied coverage by UHC or OptumHealth Behavioral Solutions. A Personal Health Advocate (PHA) experienced with healthcare claims and appeals will help get the information needed and provide assistance in filing an appeal. There is no charge for this service – it is completely free, but you must be enrolled in a Delta medical option administered by UHC and meet certain requirements, as described below.

Before You Call:

A Health Advocate, Inc. PHA can only assist if you:

- 1) Have been denied coverage of a medical or behavioral health/substance abuse claim that is clinical in nature,
- 2) Have the Explanations of Benefits (EOB) for the denied claim,
- 3) Have utilized the appropriate resources and programs at UHC or OptumHealth Behavioral Solutions that can assist you with the claim (such as a Delta Health Direct nurse or an OptumHealth Behavioral Solutions care advocate), and
- 4) Have unsuccessfully appealed the claim at lower appeal levels and are eligible for the voluntary external review which is the final level of appeal for clinically-based claims.

If you have been denied coverage, but haven't yet received the EOB, please contact UHC or OptumHealth Behavioral Solutions to obtain the EOB before calling Health Advocate. You will also need to complete the other steps described above. There are strict appeal deadlines so make certain that you complete these steps and reach out to Health Advocate, Inc. in a timely manner.

Health Advocate, Inc. can be reached 24/7 by calling **1-855-426-8585** or emailing answers@HealthAdvocate.com. The service is available for Delta employees and retirees, and their Spouses and dependent children who are covered under a Delta healthcare plan. The Delta employee, retiree or survivor should make the contact to Health Advocate, Inc. on behalf of their covered dependents. Health Advocate, Inc. is independent of and not connected with UHC, Delta, the Delta Health Direct program, OptumHealth Behavioral Solutions, or any other health plan.

Appealing Denied Claims

If you disagree with the decision made by a claims administrator about your claim, you may appeal this decision in accordance with the internal and, as applicable, external appeal procedures described below. It is important that you strictly follow these procedures. Your failure to do so may cause you to lose certain legal rights.

What to Include in Your Appeal Request

Unless otherwise indicated, your appeal request must be in writing and should include all the facts and arguments that you want considered. In addition, your appeal request should include:

- The patient's name and the identification number from the applicable provider ID card
- The name of the provider/physician/dentist/hospital
- *For pre-service appeals:*
 - The date an original pre-service request was made, the date of the proposed service, hospital admission or prescription, and the nature of the proposed service, admission or prescription
 - The reason you believe the care or prescription requiring pre-service approval should be approved or authorized
- *For post-service appeals:*
 - The date the service(s) or prescription was received and the nature of the service or prescription
 - The reason you believe the claim should be paid
- All documentation or other written information to support your request for claim payment

Access to Information

On request, you are entitled to receive, free of charge, reasonable access to and copies of the following:

- Documents, records and information relevant to your claim
- Any internal rule, guideline, protocol, or other similar criterion that was relied on in making the initial claim or appeal determination
- If the claim was denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applied to the circumstances at issue in the claim

If new or additional evidence is considered, relied upon or generated in connection with the claim, or if any new or additional rationale for a denial is discovered at the internal appeals stage, such evidence or rationale will be provided to you free of charge. You will be given a reasonable opportunity to respond to such new evidence or rationale.

About the Internal Appeal Process

All levels of appeal will be reviewed by a new decision-maker — referred to in this section as the "claims reviewer." This means that the first level of appeal will not be conducted by the individual who denied the initial claim or by that person's subordinate and, in cases when a second level of appeal is

given, the second-level appeal will not be conducted by the individual who denied the first-level appeal of the initial claim, or that person's subordinate.

The appeal process will take into account all information regarding the denied claim (whether or not presented or available when the original decision was made). The claims reviewer will not give deference to the original decision made about your claim. That is, the reviewer will give your claim a "fresh look" and make an independent decision about the claim.

If your claim was denied based on medical judgment (including determinations regarding whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the claims reviewer will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the claim. The healthcare professional will not be the same person (or a subordinate of the person) who was consulted on the initial decision. If the advice of any medical, dental or vocational experts is obtained in connection with your claim denial, upon your request, these experts will be identified, regardless of whether their advice is relied upon in deciding the appeal.

For appeals involving urgent care claims, you may request that all necessary information (including the decision) between you and the claims reviewer be transmitted by telephone or fax instead of by written or electronic means.

Medical Claim Internal Appeals

UnitedHealthcare (UHC) is the claims reviewer for medical benefits under the DABHP medical options. If your medical claim is denied by the claims administrator, you have the right to file an appeal with the claims reviewer in accordance with the process described below.

There are two internal levels of appeal for non-urgent medical claims, both of which are mandatory. There is one internal level of appeal for urgent care medical claims, which is mandatory. For both non-urgent and urgent care claims, UHC will review your claim denial. If your claim on appeal is denied in whole or in part, as a result of the second level appeal for non-urgent care claims or as a result of the first level appeal for urgent care claims, you can appeal the decision under the external review process described later in this section.

First-Level Appeal Process

Non-Urgent Care Claim Process

If you wish to appeal a claim denial involving a non-urgent care claim, you must request an appeal within 180 days of the date you received your claim denial from the claims administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process

If you wish to appeal a claim denial involving an urgent care claim, your request *does not have to be made in writing*. You or your provider should call the claims reviewer as soon as possible, but no later than 180 days after receiving the adverse benefit determination, to request an expedited appeal of the claim denial. An urgent appeal will be reviewed, a decision made, and you and your provider will be notified as soon as possible, but in no event later than 72 hours of the receipt of your request. The reviewer responsible for making determination upon appeal will defer to the patient's attending provider determination as to whether a claim constitutes urgent care.

*Second-Level Appeal Process***Non-Urgent Care Claim Process**

If your first-level appeal request was a non-urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted in writing within 60 days of the date you received notification from the claims reviewer of the outcome of your first-level appeal. Once you have filed your second-level appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Behavioral Health and Substance Abuse Claim Internal Appeals

UnitedHealthcare (UHC)/OptumHealth Behavioral Solutions is the claims reviewer for behavioral health and substance abuse (BH/SA) benefits for the medical options available under the DABHP. If your behavioral health or substance abuse claim is denied by the claims administrator, you have the right to file an appeal with the claims reviewer in accordance with the process described below.

There are two internal levels of appeal for non-urgent behavioral health or substance abuse claims, both of which are mandatory. There is one internal level of appeal for urgent care behavioral health or substance abuse claims, which is mandatory. For both non-urgent and urgent care claims, UHC/OptumHealth Behavioral Solutions will review your claim denial. If your claim on appeal is denied in whole or in part, as a result of the second level appeal for non-urgent care claims or as a result of the first level appeal for urgent care claims, you can appeal the decision under the external review process described later in this section.

*First-Level Appeal Process***Non-Urgent Care Claim Process**

If you wish to appeal a claim denial involving a non-urgent care claim, you must request an appeal within 180 days of the date you received your claim denial from the claims administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process

If you wish to appeal a claim denial involving an urgent care claim, your request *does not have to be made in writing*. You or your provider should call the claims reviewer as soon as possible, but no later than 180 days after receiving the adverse benefit determination, to request an expedited appeal of the claim denial. An urgent appeal will be reviewed, a decision made, and you and your provider will be notified as soon as possible, but in no event later than 72 hours of the receipt of your request. The reviewer responsible for making determination upon appeal will defer to the patient's attending provider determination as to whether a claim constitutes urgent care.

*Second-Level Appeal Process***Non-Urgent Care Claim Process**

If your first-level appeal request was a non-urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted in writing within 60 days of the date you received

notification from the claims reviewer of the outcome of your first-level appeal. Once you have filed your second-level appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Prescription Drug Claim Internal Appeals

UnitedHealthcare (UHC) is the claims reviewer for prescription drug benefits for the medical options available under the DABHP. If your prescription drug claim is denied by the claims administrator, you have the right to file an appeal with the claims reviewer in accordance with the process described below.

There are two internal levels of appeal available for prescription drug claims. Both levels of appeal are mandatory. If your claim on appeal is denied in whole or in part, as a result of the second level appeal, you can appeal the decision under the external review process described later in this section.

Appeal Process

If you wish to appeal a claim denial, you must request an appeal within 180 days of the date you received your claim denial from the claim administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than 30 days after the receipt of your request.

Second-Level Appeal Process

If you remain dissatisfied with the outcome of your first-level appeal review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted in writing within 60 days of the date you received notification from the claims reviewer of the outcome of your first-level appeal. Once you have filed your second-level appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than 30 days after the receipt of your request.

Dental Claim Appeals: MetLife

MetLife is the claims reviewer for dental benefits under the plans. If your dental claim is denied by the claims administrator, you have the right to file an appeal with the claims reviewer in accordance with the process described below.

There are two levels of appeal available for dental claims, and both levels are mandatory.

First-Level Appeal Process

Non-Urgent Care Claim Process

If you wish to appeal a claim denial involving a non-urgent care claim, you must request an appeal within 180 days of the date you received your claim denial from the claims administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process

If you wish to appeal a claim denial involving an urgent care claim, your request *does not have to be made in writing*. You or your dentist should call the claims reviewer as soon as possible to request an expedited appeal of the claim denial. An urgent appeal will be reviewed, a decision made, and you and your dentist will be notified within 72 hours of the receipt of your request.

*Second-Level Appeal Process***Non-Urgent Care Claim Process**

If your first-level appeal request was a non-urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted in writing within 60 days of the date you received notification from the claims reviewer of the outcome of your first-level appeal. Once you have filed your second-level appeal, the claims reviewer will notify you of its decision as soon as possible given the medical situation, but not later than the following:

- Pre-Service Claims: 15 days after the receipt of your request
- Post-Service Claims: 30 days after the receipt of your request

Urgent Care Claim Process

If your first-level appeal request was an urgent review, and you remain dissatisfied with the outcome of that review, you have the right to request a second-level appeal from the claims reviewer. Your second-level appeal request must be submitted as soon as possible after you receive notification from the claims reviewer of the outcome of your first-level appeal. This second-level appeal request *does not have to be made in writing*. You or your dentist should call the claims reviewer as soon as possible to request an expedited appeal of the first-level appeal denial. An urgent appeal will be reviewed, a decision made, and you and your dentist will be notified within 72 hours of the receipt of your request.

Healthcare FSA Claim Internal Appeals

UnitedHealthcare (UHC) and the Administrative Subcommittee are the claims reviewers for Healthcare FSA claims. If your Healthcare FSA claim is denied by the claims administrator, you have the right to file an appeal with the applicable claims reviewer in accordance with the process described below. Note that all Healthcare FSA claims are considered post-service claims.

There are two internal levels of appeal available for Healthcare FSA claims, and both levels are mandatory. UnitedHealthcare (UHC) is the claims reviewer for the first-level appeal, and the Administrative Subcommittee is the claims reviewer for the second-level appeal.

First-Level Appeal Process

If you wish to appeal a claim denial, you must request an appeal within 180 days of the date you received your claim denial from the claims administrator. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible, but no later than 30 days after the receipt of your request.

Second-Level Appeal Process

If you remain dissatisfied with the outcome of your first-level appeal review, you have the right to request a second-level appeal from the Administrative Subcommittee. Your second-level appeal request must be submitted in writing within 60 days of the date you received notification from the claims reviewer of the outcome of your first-level appeal. Once you have filed your second-level appeal, the Administrative Subcommittee will notify you of its decision as soon as possible, but no later than 30 days after the receipt of your request.

If Your Appeal Request Is Denied

If your appeal request is denied, in whole or in part, the applicable claims reviewer will provide you with a written or electronic notice of its decision, including:

- For the dental options and the Healthcare FSA, the specific reason or reasons for the denial of the appeal
- Reference to the specific plan provision(s) on which the denial is based
- A statement that you are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A description of any voluntary appeal procedures available to you under the plan and your right to obtain information about such procedures and the time limits under those procedures, and a statement regarding your right to bring an action under Section 502(a) of ERISA
- If applicable, a copy of the internal rule, guideline, protocol, or similar criterion that was relied on in making the claim determination
- If the denial is based on an exclusion for medical necessity or experimental treatment or similar exclusion limitation, a statement explaining the scientific or clinical judgment relied upon

Additionally, for healthcare benefit claims (other than dental claims), the claims administrator also will provide you with:

- Information sufficient to identify the claim involved, including the date of the service, the health care provider and the claim amount (if applicable)
- A statement that you may request and receive the diagnosis treatment codes and their meaning
- A description of the standard, if any, that was used in denying the claim and a discussion of the decision
- A description of available internal appeals and external review processes, including how to initiate an appeal
- Contact information for the applicable office of health insurance consumer assistance or ombudsman who may assist you with internal and external claims and appeals

For healthcare benefit claims (other than dental claims), if new or additional evidence is considered, relied upon or generated in connection with the claim, or if any new or additional rationale for a denial is discovered at the internal appeals stage, such evidence or rationale will be provided to you free of charge. You will be given a reasonable opportunity to respond to such new evidence or rationale.

Claims Involving Eligibility to Participate

If your claim for benefits is denied because you are not eligible to participate in the DABHP or an underlying medical plan, you will be notified of such denial in writing by the Employee Service Center (ESC).

The Administrative Subcommittee is the claims reviewer for eligibility determinations under the DABHP. If you were denied eligibility under the DABHP, you have the right to file an appeal with the claims reviewer in accordance with the process described below. There is only one level of appeal available for plan eligibility claims, and it is mandatory.

Appeal Process

If you wish to appeal a claim denial, you must request an appeal within 180 days of the date you received your claim denial from the ESC. Once you have submitted your appeal, the claims reviewer will notify you of its decision as soon as possible, but no later than 60 days after the receipt of your request.

External Review Process for the Medical Options Only

The external review process offers an independent review of the denial of eligible medical, behavioral health/substance abuse care or prescription drug claims. If you have exhausted the internal appeals process and you remain unsatisfied with the outcome of your appeal(s) or if the claims administrator fails to respond to your appeal in a timely manner, you may be eligible to file a request for an external review.

The external review process is available at no charge to you, but only for certain claims, including those relating to:

- Medical judgment (other than claims involving contractual or legal interpretations)
- Exclusions of experimental or investigational services or unproven services
- Rescission of coverage (coverage that was cancelled or discontinued retroactively)

If the above conditions are satisfied, you may request an external review of your denied claim. All requests for an external review must be made within four months of the date you receive the denial. You or an authorized designated representative may request an external review by contacting the toll-free number on your ID card or by sending a written request to the address in your claim determination letter.

An external review request should include all of the following:

- A specific request for an external review
- The participant's name, address and ID number
- A designated representative's name and address, if applicable
- The service that was denied
- Any new, relevant information that was not provided during the internal appeals process

An external review will be performed by an Independent Review Organization (IRO). The claims administrator has entered into agreement with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review, and
- An expedited external review

Standard External Review

A standard external review is comprised of the following:

- A preliminary review by the claims administrator
- A referral of the request by the claims administrator to the IRO
- A decision by the IRO

Within five business days following the date of receipt of your external review request, the claims administrator will complete a preliminary review of your request to determine whether your claim is eligible for external review, that you have exhausted the applicable internal appeals process and that you have provided all the information and supporting documentation necessary to process an external review.

After completing the preliminary review, the claims administrator will issue a written notification to you. If the request is eligible for external review, the claims administrator will assign an IRO to conduct the review. The claims administrator assigns requests by either rotating claims assignments among the IROs or by using a random selection process.

If the request is complete, but not eligible for external review, the notification will include the reasons for the determination. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In this case, you must provide the claims administrator with the additional information or materials within the later of the end of the four-month filing period described above or within the 48 hours following your receipt of the notification.

Within 48 hours of providing the claims administrator with a complete eligible external review request, the request will be forwarded to the assigned IRO, together with:

- All relevant medical records
- All other documents relied upon by the claims administrator in making a decision on the case
- All other information or evidence that you or your physician has already submitted to the claims administrator. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an external review and the claims administrator will include it with the documents forwarded to the IRO

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the claims administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the claims administrator, and it will include the clinical basis for the determination. Neither you nor the claims administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If the Final External Review Decision is to approve your claim, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan. If the Final External Review Decision is that the claim remains denied, the Plan will not be obligated to provide benefits for the service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility

Immediately upon receipt of the request, the claims administrator will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided
- Has provided all the information and forms required so that UHC may process the request

After the claims administrator completes the review, the claims administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the claims administrator will assign an IRO in the same manner utilized for assigning standard external reviews to IROs. The claims administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the claims administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the claims administrator.

You may contact UHC at the toll-free number on your ID card for more information regarding your external review rights, or if making a verbal request for an expedited external review.

Other Important Information About Appeals

The DABHP uses the claims and appeal procedures outlined in this section to ensure that the plans' provisions are correctly and consistently applied. The decisions of the final claims reviewers are conclusive and binding. Once you exhaust the mandatory levels of appeal, no further review of your claim is available under the terms of the DABHP.

Exhaustion of Administrative Remedies

For the Medical Options

Before starting legal action to recover benefits under any of the medical options available under the DABHP, or to enforce or clarify rights, you must completely exhaust the plans' claims and appeal procedures. This means that you must complete all mandatory levels of appeal described in this handbook before you may request an external review or sue for benefits under the DABHP.

For the Dental Options and the Healthcare FSA

Before starting legal action to recover benefits under the dental options available under the DABHP or the Healthcare FSA, or to enforce or clarify rights, you must completely exhaust the plans' claims and appeal procedures. This means that you must complete all mandatory levels of appeal described in this handbook before you may sue for benefits under the plans.

Limitation of Action

You cannot bring any legal action against Delta Air Lines, Inc. or the claims administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. In no event may you bring any legal action or proceeding for benefits under the DABHP later than one year following the date on which you have exhausted all administrative remedies available to you under the Plan.

Grievances (For ALPA or PAFCA Represented Employees Only)

After following the preceding claims and appeal procedures, if your claim is still denied in whole or in part, you may be able to file a grievance under the terms of your collective bargaining agreement.

Part 2 – Other Claims and Appeals Procedures

Health Plan Hawaii

The Health Plan Hawaii option is administered by Hawaii Medical Services Association (HMSA). All claims and appeals of denied claims are handled exclusively by HMSA. Contact HMSA at **808-948-6372** for details about claims and appeal procedures.

Humana Health Plan of Puerto Rico

The Humana Health Plan of Puerto Rico option is administered by Humana. All claims and appeals of denied claims are handled exclusively by Humana. Contact Humana at **787-282-7900 ext. 5500** for details about claims and appeal procedures.

Vision Claims and Appeals

The vision plan is administered by EyeMed Vision Care. All claims and appeals of denied claims are handled exclusively by EyeMed Vision Care. Contact EyeMed Vision Care Member Services at **833 DELTA VP (833-335-8287)** for details about claims and appeal procedures.

Dependent Care FSA Claims/Claim Appeals

UnitedHealthcare (UHC) is the claims administrator for Dependent Care Flexible Spending Account (FSA) benefits.

You will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your Dependent Care FSA for the Eligible Expenses that have been incurred. You may submit Dependent Care FSA claims for reimbursement at any time during the plan year; however, reimbursement can only be made up to your current account balance.

- Expenses must be incurred between January 1 (or your date of hire, or date of enrollment, if later) and December 31 of the plan year (or your termination date, or date of discontinuance of participation, if earlier) to be eligible for reimbursement. If you begin participating in the Dependent Care FSA partway through the year, you may only be reimbursed for Eligible Expenses that you incur from the date you begin participating through December 31 of that year
- You have until March 31 of the following plan year to submit your claim. Expenses are incurred as of the date the service is provided, not when you are billed or pay for services

To download a claim form for reimbursement from your Dependent Care FSA, visit **myuhc.com**. You may also search for FSA claim form on Deltanet. If you do not have access to the Internet, contact the ESC at **1-800 MY DELTA (1-800-693-3582)** for assistance.

Complete the claim form and attach the appropriate documentation, as outlined in the form. Your claim should include your dependent's name and age, the dates of services provided, the provider's name and address, a provider-signed receipt or invoice of itemized dates/services, and the provider's tax ID number or Social Security number. Be sure to make copies of all documentation for your records.

FSA Claims Payment

Your payment will come to you in one of two ways:

- The approved amount of your FSA claim is mailed to you in the form of a check. Checks are mailed bi-weekly
- If you have elected Electronic Funds Transfer (EFT), the approved amount is deposited directly into your checking or savings account

To help you maintain your records, your reimbursement check is accompanied by an explanation of each reimbursement and a statement of how much money remains in your account. You may set up EFT and the automatic payment method, as well as view your explanation of benefits on **myuhc.com**.

If your Dependent Care FSA claim is denied in whole or in part, you receive a written explanation of the reasons for the denial. You may contact UHC by calling Delta Health Direct at **877-912-1820** for clarifications regarding this denial; however, there is no formal appeal procedure available, and UHC's decision is considered final.

COBRA Coverage Cancellation/Denial Appeals

If Conduent HR Services LLC for Delta Air Lines (Conduent HR Services) cancels or denies your COBRA coverage, you will receive notification of the denial or cancellation from Conduent HR Services. As a COBRA participant, you have the right to initiate a formal review by Conduent HR Services of the cancellation or denial.

Initiating a Review

If you have questions about the denial or cancellation of your COBRA coverage, please call the ESC at **1-800 MY DELTA (1-800-693-3582)**. To initiate a review of the denial or cancellation, you must send a written review request to Conduent HR Services within 60 days of your notification of the cancellation or denial.

Conduent HR Services will review your request and provide you with a written determination within 60 days of receipt of the request.

If the initial cancellation/denial is upheld by Conduent HR Services, you will be advised of your option to appeal to Delta's Administrative Subcommittee.

Appealing Review Determinations

If you decide to appeal the review determination, you or your authorized representative has 90 days to submit a written appeal to the Administrative Subcommittee. The date reflected at the top of Conduent HR Services' notification letter counts as the first day in determining the 90-day period. The Administrative Subcommittee expressly reserves the right to refuse any tardy appeals.

Once you have submitted your appeal, the Administrative Subcommittee will notify you of its decision as soon as possible, but no later than 60 days after the receipt of your request.

Appealing Coverage Termination Due to Nonpayment

Termination for Nonpayment

When your outstanding balance is 90 or more days delinquent, a Termination for Nonpayment Notice will be mailed to you. When terminated for nonpayment, all of your coverages will be cancelled, except for benefits with zero cost (due to waiver of Premium or because they are Delta-paid benefits). This cancellation will be effective on the last date in which the Premiums for a *full* month are paid. If you have made a partial Premium payment, the partial payment will be refunded during the regularly scheduled refund process, because partial payments are not accepted.

Once coverage is terminated for nonpayment, coverage cannot be reinstated until you return to active payroll status. Retirees and survivors whose coverage is terminated for nonpayment of Premiums will not be allowed future enrollment rights under the plans. See "Paying for Coverage" in the "Enrolling for Healthcare and Flexible Spending Accounts Benefits" section of this handbook for details.

Reinstatements

Reinstatements are not permitted for inactive participants whose coverages are terminated because of nonpayment. If a participant's status changes to active, coverage will be reinstated as of the effective date of the active status.

Appealing Coverage Terminations Due to Nonpayment

If you believe that your medical, dental or vision coverage was terminated in error, you may appeal the termination due to nonpayment of Premiums if you are a retiree, survivor or disabled participant only.

If your coverage is terminated due to nonpayment of Premiums, you will receive a Termination for Nonpayment Notice. This notice will inform you that you have 90 days to submit a written appeal to the Administrative Subcommittee. The date at the top of the Termination for Nonpayment Notice counts as the first day in determining the 90-day period. Once you have submitted your appeal, the Administrative Subcommittee will notify you of its decision as soon as possible, but no later than 60 days after the receipt of your request.

The Administrative Subcommittee expressly reserves the right to refuse any tardy appeals. A review is made only upon the written record.

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Claims and Appeals General Information

Claims Review and Appeals Information at a Glance			
	Claims Administrator	Claims Reviewer	Contact Information
Medical Claims			
DABHP	UnitedHealthcare (UHC)	UHC Member Services	<p>UnitedHealthcare Claims Department P.O. Box 740800 Atlanta, GA 30374-0800 Delta Health Direct: 877-912-1820</p> <p>UnitedHealthcare Appeals Department P.O. Box 740816 Atlanta, GA 30374</p> <p><i>UPS/Fed Ex Delivery Address:</i> UnitedHealthcare Appeals Department 4316 Rice Lake Road Duluth, MN 55811</p>
Health Plan Hawaii (HMO)	Hawaii Medical Services Association (HMSA)	Health Plan Hawaii Member Services	<p>Member Services 818 Keeaumoku Street Honolulu, HI 96814 808-948-6372 (Mon – Fri: 8 a.m.–4 p.m.)</p>
Humana Health Plan of Puerto Rico	Humana Health Plan	Humana Health Plan of Puerto Rico Member Services	<p>Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave. FD Roosevelt Ave San Juan, Puerto Rico 00918-2131 787-282-7900 ext. 5500</p>

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Claims Review and Appeals Information at a Glance

	Claims Administrator	Claims Reviewer	Contact Information
Behavioral Health & Substance Abuse Claims			
DABHP	UnitedHealthcare (UHC)/ OptumHealth Behavioral Solutions	UHC/OptumHealth Member Services	UHC/OptumHealth Behavioral Solutions Appeals & Grievances P.O. Box 30512 Salt Lake City, UT 84130-0512 866-556-8166 Fax: 855-312-1470 <i>UPS/Fed Ex Delivery Address:</i> OptumHealth Behavioral Solutions Appeals Attn: PO Box 30512 4050 South 500 West Salt Lake City, UT 84123
Health Plan Hawaii (HMO)	Hawaii Medical Services Association (HMSA)	Health Plan Hawaii Member Services	Member Services 818 Keeaumoku Street Honolulu, HI 96814 808-948-6372 (Mon – Fri: 8 a.m.–4 p.m.)
Humana Health Plan of Puerto Rico	Humana Health Plan	Humana Health Plan of Puerto Rico Member Services	Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave, FD Roosevelt Ave San Juan, Puerto Rico 00918-2131 787-282-7900 ext. 5500

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Claims Review and Appeals Information at a Glance

	Claims Administrator	Claims Reviewer	Contact Information
Prescription Drug Claims			
DABHP	UnitedHealthcare (UHC)	UHC Member Services	<p>OptumRx Attn: Claims Department P.O. Box 29077 Hot Springs, AR 71903 Delta Health Direct: 877-912-1820</p> <p>UnitedHealthcare Appeals Department P.O. Box 740816 Atlanta, GA 30374</p> <p><i>UPS/Fed Ex Delivery Address:</i> UnitedHealthcare Appeals Department 4316 Rice Lake Road Duluth, MN 55811</p>
Health Plan Hawaii (HMO)	Hawaii Medical Services Association (HMSA)	Health Plan Hawaii Member Services	<p>Member Services 818 Keeaumoku Street Honolulu, HI 96814 808-948-6372 Monday – Friday: 8 a.m.–4 p.m.</p>
Humana Health Plan of Puerto Rico	Humana Health Plan	Humana Health Plan of Puerto Rico Member Services	<p>Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave, FD Roosevelt Ave San Juan, Puerto Rico 00918-2131 787-282-7900 ext. 5500</p>
Dental Claims			
DABHP	Metropolitan Life Insurance Company (MetLife)	MetLife Dental Customer Service Center	<p>MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 855-700-7992 Fax – 1-859-389-6505</p> <p>MetLife Dental Appeals P.O. Box 14589 Lexington, KY 40512</p>

HEALTHCARE BENEFITS HANDBOOK

Claims Review and Appeals Information at a Glance

	Claims Administrator	Claims Reviewer	Contact Information
Vision Claims			
EyeMed Vision Care	EyeMed Vision Care	EyeMed Vision Care Member Services	First American Administrators Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 833 DELTA VP (833-335-8287)
FSA Claims			
Healthcare Flexible Spending Accounts <ul style="list-style-type: none"> Limited Purpose FSA Full Purpose FSA 	UnitedHealthcare (UHC)	UHC Member Services	<p><i>Claims & First-Level Appeals:</i> UnitedHealthcare Healthcare Account Service Center P.O. Box 981506 El Paso, TX 79998-1506</p> <p><i>Claims:</i> Delta Health Direct: 877-912-1820</p> <p><i>Appeals:</i> 877-311-7849 Fax: 915-231-1709 or 866-262-6354</p> <p><i>Second-Level Appeal:</i> Secretary, Administrative Subcommittee Delta Air Lines, Inc. Department 844 P.O. Box 20706 Atlanta, GA 30320 404-715-2600 Fax: 404-773-1362</p> <p><i>UPS/Fed Ex Delivery Address:</i> UnitedHealthcare Attn: FSA 43 Butterfield Circle El Paso, TX 79998-1178</p>

HEALTHCARE BENEFITS HANDBOOK

Claims Review and Appeals Information at a Glance

	Claims Administrator	Claims Reviewer	Contact Information
COBRA Coverage Cancellation/Denial			
COBRA Coverage	Conduent HR Services LLC for Delta Air Lines	Conduent HR Services LLC for Delta Air Lines	<p><i>Review of Cancelled/Denied Coverage:</i> Delta Employee Service Center P.O. Box 52045 Phoenix, AZ 85072 1-800 MY DELTA (1-800-693-3582)</p> <p><i>Appeal:</i> Secretary, Administrative Subcommittee Delta Air Lines, Inc. Department 844 P.O. Box 20706 Atlanta, GA 30320 404-715-2600 Fax: 404-773-1362</p>
Eligibility Issues			
Eligibility for Delta Healthcare Benefits	Administrative Subcommittee of Delta Air Lines	Administrative Subcommittee of Delta Air Lines	<p><i>Claim Review and Appeal:</i> Secretary, Administrative Subcommittee Delta Air Lines, Inc. Department 844 P.O. Box 20706 Atlanta, GA 30320 404-715-2600 Fax: 404-773-1362</p> <p><i>For Eligibility Claim Questions:</i> Employee Service Center 1-800 MY DELTA (1-800-693-3582)</p>

PLAN ADMINISTRATION AND LEGAL RIGHTS

HEALTHCARE BENEFITS HANDBOOK

PLAN ADMINISTRATION AND LEGAL RIGHTS

Definitions of Capitalized Words

The capitalized terms used in this handbook have special meaning. Refer to the "Terms to Know" section at the end of this handbook for definitions.

This section contains a description of general administrative and legal information applicable to the plans, of which medical, dental, vision and medical expense reimbursement benefits are a part.

Plan Information

This handbook describes the following plans. These are referred to collectively in this section as "the plans."

Benefit	Formal Plan Name	Plan Number	Plan Type	Administration	Fiscal Year
Medical, Prescription Drug and Dental	Delta Account-Based Healthcare Plan	544	Welfare benefit plan providing medical, prescription drug and dental benefits	Contract administered	July 1 – June 30
Vision	Delta Vision Plan	532	Welfare plan providing vision benefits	Insurer administered	Jan. 1 – Dec. 31
Healthcare Flexible Spending Accounts (FSAs)	Delta Air Lines Medical Reimbursement Plan	521	Plans providing medical expense reimbursement	Contract administered	July 1 – June 30
	Delta Pilots Medical Reimbursement Plan	525			

Plan Sponsor/Employer/EIN

The Plan Sponsor and employer is Delta Air Lines, Inc. You may contact the Plan Sponsor at the following address:

Delta Air Lines, Inc.
P.O. Box 20706
Atlanta, GA 30320-6001

The Employer Identification Numbers (EINs) assigned by the IRS for Delta and the following subsidiaries are:

- Delta Air Lines, Inc.: 58-0218548
- Delta Vacations, LLC (Delta Vacations): 41-0946976
- Delta Material Services, LLC (DMS): 47-5067068
- Delta Flight Products, LLC (DFP): 81-3610445

Labor Organization Members Covered by the Plans

Members of the Professional Airline Flight Controllers Association participate in the Delta Account-Based Healthcare Plan pursuant to the terms of a labor agreement.

Professional Airline Flight Controllers Association (PAFCA)
P.O. Box 20762
Atlanta, GA 30320

Participants and beneficiaries covered by the labor agreements may obtain a copy of the applicable agreement by sending a request to:

Secretary, Administrative Committee
Delta Air Lines, Inc.
Department 844
P.O. Box 20706
Atlanta, GA 30320-6001

Agent for Service of Legal Process

The agent for service of legal process on the plans, and the address where process can be served, is:

Secretary, Administrative Committee
Delta Air Lines, Inc.
Department 981
1030 Delta Boulevard
Atlanta, GA 30354

Legal service of process for the Delta Account-Based Healthcare Plan also can be made upon the Trustee of the trust for the plan.

Plan Administrator

The Administrative Committee of Delta Air Lines, Inc. is the plan administrator of the plans. It is the named fiduciary for administration of the plans and is responsible for:

- Operation and administration of the plans (except for purposes of formulating and managing the investment policies and controlling the plans' assets, if any, that are instead the responsibilities of the Benefit Funds Investment Committee of Delta)
- Exclusive power to construe and to interpret the plans and determine questions of eligibility for participation and receipt of benefits
- Determining the amount, the manner and the time of payment of benefits
- Authorizing the payment of benefits and reasonable expenses for administering the plans
- Carrying out the provisions of the plans pertinent to the responsibility of the Administrative Committee
- Delegation of any of its fiduciary authority to determine and review claims

In exercising its functions, the Administrative Committee or its delegate has the broadest discretionary authority permitted under law. Members of the Administrative Committee are appointed by the Executive Vice President – Human Resources of Delta. The Administrative Committee members may be substituted or removed from their positions at the sole discretion of the Executive Vice President – Human Resources. They receive no compensation in their capacities as members, but receive compensation as employees of Delta.

The address and telephone number of the Administrative Committee are:

The Administrative Committee of Delta Air Lines, Inc.
Department 844
P.O. Box 20706
Atlanta, GA 30320-6001
404-715-2600

HEALTHCARE BENEFITS HANDBOOK

Claims Administrator

The following insurers are claims administrators for the plans and process claims payments. In addition, EyeMed Vision Care insures the vision plan, and, therefore, is financially responsible for the benefits of that plan. Likewise, Hawaii Medical Service Association insures the HMSA medical HMO benefits and Humana insures the Health Plan of Puerto Rico. These entities are, therefore, financially responsible for those benefits.

Plan	Claims Administrator/Insurer
<p>Delta Account-Based Healthcare Plan – medical benefits</p> <p>Delta Account-Based Healthcare Plan – Medical HMO benefits</p> <p>Hawaii Health Plan</p> <p>Humana Health Plan of Puerto Rico</p>	<p>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 Delta Health Direct: 877-912-1820</p> <p>Hawaii Medical Service Association 818 Keeaumoku Street Honolulu, HI 96814 808-948-6372</p> <p>Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave F D Roosevelt San Juan, Puerto Rico 00918-2131 787-282-7900 ext. 5500</p>
<p>Delta Account-Based Healthcare Plan – dental benefits</p>	<p>MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 855-700-7992 Fax – 1-859-389-6505</p>
<p>EyeMed Vision Plan</p>	<p>First American Administrators Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 833 DELTA VP (833-335-8287)</p>
<p>Delta Air Lines Medical Reimbursement Plan and Delta Air Lines Pilots Medical Reimbursement Plan – Healthcare FSA benefits</p>	<p>UnitedHealthcare FSA Unit P.O. Box 981506 El Paso, TX 79998-1506 Delta Health Direct: 877-912-1820</p>

Discretionary Authority of the Plan Administrator and the Claims Administrator

The Administrative Committee has delegated to UnitedHealthcare, Metropolitan Life Insurance Company (MetLife), and their affiliates (“Claims Administrators”) the authority to determine claims eligibility and benefit amounts in accordance with the plans’ terms. As such, the Claims Administrators have the broadest discretionary authority permitted under law to interpret the provisions of the plans and determine eligibility for benefits.

The Claims Administrator serves as the final reviewer under the plans and has sole and complete discretionary authority to determine conclusively any and all questions concerning the administration and interpretation of the plans, including questions about eligibility to participate in the plans; eligibility for benefits; the relevant facts; the amount and type of benefits payable to any participant; and the construction of all terms of the plans. Notwithstanding the foregoing, the Plan Administrator will have sole and complete discretionary authority to determine questions relating to eligibility of healthcare benefits pursuant to the voluntary appeal process available for such benefits under the plans.

Respective decisions by the Plan Administrator and the Claims Administrator will be final, conclusive and binding on all parties claiming to have an interest in the plans and not subject to further review by the Company. Benefits will be paid under the plans only if the Claims Administrator or the Plan Administrator decides, in its sole authority, that the participant or other claimant is entitled to them.

Plan Fiduciaries

The members of the Administrative Committee are the named fiduciaries for purposes of operation and administration of the plans. However, the Administrative Committee delegated the complete and broadest discretion to decide and review certain benefit claims to its Claims Administrators, as previously described.

The members of the Benefit Funds Investment Committee are the named fiduciaries for formulating the investment policies and managing/controlling the assets of the plans, if any. Among its duties, the Benefits Fund Investment Committee or its delegate appoints (and discharges) investment managers and trustees to manage and maintain custody of the assets of the plans.

Source of Contributions and Funding

The healthcare benefits under the Delta Account-Based Healthcare Plan are self-funded by Delta, Delta Vacations, DMS and DFP, as applicable, through a Trust. The plan is also funded through the contributions of participants and beneficiaries of the plan. The benefits under the Delta Vision Plan, the HMSA Hawaii HMO and Humana Health Plan of Puerto Rico are insured products, and the benefits of those plans are not funded by the Company. However, the participant, and in some cases, Delta, Delta Vacations, DMS or DFP, as applicable, makes Premium payments to the insurer for those benefits. Active and inactive Premiums are determined annually by the Company, or in the case of contractually offered plans, based on the terms of the applicable labor agreement. Retiree and survivor Premiums are a percentage of the applicable cost of each plan, and such cost may change on an annual basis.

Employee and Retiree Contributions

Generally, employee medical/dental contributions are a portion of the full cost of the coverage, as determined by the Company each year, or in accordance with applicable collective bargaining agreements. The full cost of the coverage is determined by the plans' actuary, who takes into account the claims experience, expected medical inflation, plan design and other factors in setting the rates. The employee Premium amount is also based on the option chosen and the number of dependents covered. Employee Premium amounts for all available medical and dental options are displayed in the Benefits Direct enrollment tool during the annual open enrollment period. In addition, you can view your Premium deductions during the year by visiting Benefits Direct on Deltanet, clicking on "Self Service" and then "Benefits Direct".

Retiree Premiums for medical/dental coverage for Delta retirees are determined by a number of factors. They, too, are a percentage of the full cost of the coverage as determined by Delta, or in accordance with the applicable collective bargaining agreements. The full cost of the coverage is determined by the plans' actuary, who takes into account the claims experience, expected medical inflation, plan design and other factors in setting the rates. The retiree's contribution amount is also based on the options chosen and the number of dependents covered. The 2019 retiree Premiums for the DABHP are 100% of the cost of the coverage until age 65, when coverage is no longer offered. To see the full retiree cost amounts, visit Benefits Direct on Deltanet.

Organizations That Accumulate Assets or Provide Benefits

The Delta Account-Based Healthcare Plan is funded through the Delta Account-Based Medical Trust, a 501(c)(9) voluntary employee beneficiary association, to which Delta, Delta Vacations, DMS and DFP, as applicable, contribute. Participant contributions to this plan are also placed in the Trust. In addition to the assets of the plan that are in the trust fund, some benefits are provided through an insurance company and through the general assets of the companies listed under "Plan Information," earlier in this "Plan Administration and Legal Rights" section. The trustees, the insurance companies and the companies listed under "Plan Information" earlier in this section make benefit payments as directed by the Administrative Committee or its delegates.

Medical benefits for participants electing the HMSA HMO option or the Humana Health Plan of Puerto Rico are provided by the Health Maintenance Organization (HMO). The Vision Plan is an insured plan that is administered by EyeMed Vision Care and underwritten by Fidelity Security Life Insurance Company.

Plan Trustee

The following entity serves as the trustee of the Delta Account-Based Healthcare Plan Trust:

JPMorgan Chase Bank, N.A.
270 Park Avenue
New York, NY 10017

Electronic Media

The Plan Administrator may use electronic media in accordance with the provisions of ERISA to satisfy all disclosure and recordkeeping obligations imposed on the plans under Title I of ERISA.

Assignment of Benefits

Except as required by law, no benefit, payment or distribution under the plans will be subject to the claim of any creditor of a participant, or to any legal process by any creditor of the participant, and the participant will not have any right to alienate, commute, anticipate or assign all or any portion of any benefit, payment or distribution under the plans.

However, a participant may make a voluntary and revocable assignment, but only for such purposes as the Plan Administrator may specify from time to time.

Assistance in Reading the English Language

If, due to language translation difficulties, a participant needs assistance in interpreting this handbook, he or she may contact the Employee Service Center (ESC) at **1-800 MY DELTA (1-800-693-3582)** for assistance. A service center representative will be pleased to work with the participant to provide the necessary explanations of rights and obligations under the plans, as well as the procedures to be followed in obtaining needed assistance.

Right to Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Under certain circumstances, participants may have the right to continue coverage under COBRA continuation coverage. For details, refer to the "COBRA Continuation Coverage" section that appears earlier in this handbook.

Filing Claims and Appealing Denied Claims

Refer to the "Claims Information & Appeals" section for information about filing claims, requesting a review of a denied claim, and appealing denied claims.

Statement of ERISA Rights

As a participant in the benefit plans described in this handbook, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all benefit plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA)
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plans, including insurance contracts, copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may request a reasonable charge for the copies
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report

Continue Group Health Plan Coverage

- Continue healthcare coverage for yourself, your Spouse, or dependent if there is a loss of coverage under a health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this handbook and the documents governing the plans for the rules governing your COBRA continuation coverage rights
- Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a health and welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of plan documents or the latest annual report from the plans and do not receive it within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a Qualified Medical Child Support Order, you may file suit in federal court
- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (if, for example, it finds your claim is frivolous)

Assistance With Your Questions

If you have any questions about any of the healthcare benefit plans offered by the Company, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory.

Or you can contact the Department of Labor's Division of Technical Assistance and Inquiries by writing to:

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **866-275-7922**. You also may visit EBSA's website at www.dol.gov/ebsa.

Other Legal Notices

The Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to fewer than 48 hours following a vaginal delivery, or fewer 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 newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act went into effect on January 1, 1999. This law contains protections for breast cancer patients who seek breast reconstruction after undergoing a mastectomy. Specifically, the medical plan participant who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction will be provided with coverage for services determined by the attending physician and the patient that include:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas

For more information regarding specific coverage levels, refer to your medical option's description of Breast Reconstruction or Reduction Surgery included in the "Medical" section of this handbook. If you are a participant in a Company-offered HMO, contact your HMO for more information (see the "Where to Get More Information" section at the back of this handbook).

Obstetrical or Gynecological Care

You do not need prior authorization from the Delta Account-Based Healthcare Plan in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including prior notice to the plan for certain services. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact UHC by calling Delta Health Direct at **877-912-1820**.

Michelle's Law

Michelle's Law extends eligibility for group health benefit plan coverage to certain dependents between age 18 and the plan's maximum age that are enrolled in coverage at the time that they take a medically necessary leave of absence from a post-secondary educational institution due to a serious illness or injury. Specifically, the law extends eligibility to those enrolled dependent children who have been full-time students at the time of an illness, but would lose coverage when a medically necessary leave of absence causes the child to fall below the course load required for full-time student status. This extension of eligibility is available for up to one year.

You must notify the Employee Service Center (ESC) and request an extension of eligibility for your dependent within 60 days of the illness or injury that was the cause for the medically necessary leave of absence.

Patient Protection and Affordable Care Act (the Affordable Care Act) Notice of Grandfathered Status

The Delta Account-Based Healthcare Plan believes the following options under the plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act): PPO Option B and PPO Option B OOA. The Delta Air Lines, Inc. Employee Assistance Plan is also a grandfathered health plan under the Affordable Care Act.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your option may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health options must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to in writing to the Employee Service Center; P.O. Box 52045; Phoenix, AZ 85072 or by phone at **1-800 MY DELTA (1-800-693-3582)**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This Web website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**.

Notice Regarding Wellness Program

The Delta Health Rewards Program (the "program") is a voluntary wellness program open to participants in the Delta Account Based Healthcare Plan. It is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the program you will be asked to complete a voluntary online Rally Health Survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., lung problems or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for testing of your total cholesterol and Fasting Blood Sugar (FBS). You are not required to complete the online Rally Health Survey or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the online Rally Health Survey or participate in the biometric screening will receive an incentive in the form of Delta Health Rewards employer contributions to an HSA or HRA as outlined in the chart on the previous page. Although you are not required to complete the online Rally Health Survey or participate in the biometric screening, only plan participants who do so will receive the employer contribution for these health actions under the program.

If you are unable to participate in any of the health-related activities (biometric screenings or quit tobacco program), you may be entitled to a reasonable alternative if your personal physician provides a statement that the wellness coaching, Rally Missions or quit tobacco program is not medically appropriate for that individual. The personal physician should fill out, sign and send the Provider Alternative Action Form, carefully following all directions on the form. Forms for employees can be downloaded from the Delta Health Rewards page on Deltanet. Forms for covered Spouses can be downloaded from myuhc.com.

The information from your online Rally Health Survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Delta Account-Based Health Care Plan, such as disease management and health improvement programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

The health plan is required by law to maintain the privacy and security of your personally identifiable health information. The Delta Health Rewards Program (the "program") will not disclose your individual health information to Delta. However, the program and Delta may use aggregate information collected to design a program based on identified health risks in the workplace. The program will never disclose any of your personal health information except as necessary to respond to a request from you for a reasonable alternative or unless expressly permitted by law. Medical information that personally identifies you that is provided in connection with the program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are UnitedHealthcare nurses, specialists and wellness coaches in order to provide you with services under the program.

In addition, all medical information obtained through the program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the program, you will be notified immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, contact Delta Health Direct at 877 912 1820. Or, if your question is about protections against discrimination and retaliation, please contact the Ethics & Compliance HelpLine at 800-253-7879.

HIPAA Privacy Notice

This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. You have the legal right to receive this Notice. It is available on Benefits Direct via Deltanet or you may request a copy by calling **1-800 MY DELTA (1-800-693-3582)**. Please review it carefully.

Notice of Special Enrollment Rights

If you decline medical plan enrollment for yourself or your dependents (including your Spouse) because of other health insurance coverage (including Marketplace coverage), you may, in the future, be able to enroll yourself or your dependents in the plan, provided that you request enrollment within 60 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

CHIPRA Special Enrollment Rights

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **1-866-444-EBSA (3272)**.

HEALTHCARE BENEFITS HANDBOOK

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. You should contact your state for further information on eligibility.

State	Contact Information
ALABAMA – Medicaid	Website: http://www.myalhipp.com Phone: 855-692-5447
ALASKA – Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
Arkansas – Medicaid	Website: http://myarhipp.com/ Phone: 855-MyARHIPP (855-692-7447)
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800-221-3943/ State Relay 711 CHP+ Website: www.Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 800-359-1991/ State Relay 711
FLORIDA – Medicaid	Website: https://www.flmedicaidtprecovery.com/hipp Phone: 877-357-3268
GEORGIA – Medicaid	Website: http://dch.georgia.gov/medicaid – Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA – Medicaid	Healthy Indiana Plan for low-income adults 19-64: Website: http://www.in.gov/fssa/hip/ Phone: 877-438-4479 All other Medicaid: Website: http://www.indianamedicaid.com Phone: 800-403-0864
IOWA – Medicaid	Website: http://dhs.iowa.gov/hawk-i Phone: 800-257-8563
KANSAS – Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 785-296-3512
KENTUCKY – Medicaid	Website: http://chfs.ky.gov Phone: 800-635-2570
LOUISIANA – Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888-695-2447
MAINE – Medicaid	Website: http://www.maine.gov/dhhs/ofl/public-assistance/index.html Phone: 800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800-862-4840

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State	Contact Information
MINNESOTA – Medicaid	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 800-657-3739
MISSOURI – Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084
NEBRASKA – Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	Website: https://dhcfp.nv.gov Phone: 800-992-0900
NEW HAMPSHIRE – Medicaid	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 888-901-4999
NEW JERSEY – Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 800-701-0710
NEW YORK – Medicaid	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 800-541-2831
NORTH CAROLINA – Medicaid	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844-854-4825
OKLAHOMA – Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 888-365-3742
OREGON – Medicaid	Websites: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 800-699-9075
PENNSYLVANIA – Medicaid	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 800-692-7462
RHODE ISLAND – Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	Website: http://www.scdhhs.gov Phone: 888-549-0820
SOUTH DAKOTA – Medicaid	Website: http://dss.sd.gov Phone: 888-828-0059

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State	Contact Information
TEXAS – Medicaid	Website: https://www.gethipptexas.com/ Phone: 800-440-0493
UTAH – Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877-543-7669
VERMONT– Medicaid	Website: http://www.greenmountaincare.org Phone: 800-250-8427
VIRGINIA – Medicaid and CHIP	Medicaid Website: www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 855-242-8282
WASHINGTON – Medicaid	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid	Website: http://mywvhipp.com/ Phone: 855-MyWVHIPP (855-699-8447)
WISCONSIN – Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800-362-3002
WYOMING – Medicaid	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

Or

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

This document appears on the following pages.

Important Notice from Delta Air Lines, Inc. About Your Prescription Drug Coverage and Medicare

Please read this Notice carefully and keep it for future reference. We are required to send it to you if you and/or your eligible dependents are eligible for Medicare. This Notice has information about your current prescription drug coverage with Delta Air Lines, Inc. ("Delta") and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a Medicare drug plan. If you are considering joining, you should compare your current coverage including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This Notice also explains where to find more information to help you make a decision about your prescription drug coverage. If you enroll in a Medicare prescription drug plan, you may need to give a copy of this Notice when you join to show that you are not required to pay a higher premium amount.

What is Medicare Part D?

In 2006, Medicare prescription drug coverage became available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. These Medicare drug plans are commonly referred to as *Medicare Part D plans*. All Medicare drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Why am I getting this Notice?

In this Notice, Delta is required to give you certain information about the prescription drug coverage that you have under the various options of the Delta health plans and how that coverage compares to the Medicare Part D coverage. Specifically, we have to inform you whether the prescription drug coverage under the various Delta health plan options is "Creditable Coverage" or "Non-Creditable Coverage" and what that means to you and your Medicare Part D coverage. The first section of this Notice describes Creditable Coverage. The second section of this Notice describes Non-Creditable Coverage. Since whether or not you will have Creditable Coverage depends on the Delta health plan option that you elect, you should read both sections of this Notice. **You should also read the question and answer at the end of the Notice ("What Should I do Next?")**

CREDITABLE Prescription Drug Coverage Notice
(Applies to the Following Plans and Options)

- Delta Pilots Medical Plan (DPMP)
- DPMP OOA
- Flight Dispatchers Medical Option (FDMO)
- FDMO OOA
- Health Reimbursement Account (HRA)
- OOA HRA
- Gold Health Savings Account (HSA)
- OOA Gold HSA
- PPO Option B
- PPO Option B OOA
- San Francisco Medical Option
- Standard Medical Option
- Standard Medical Option (OOA)

The medical benefit options under the Delta health plans provide prescription drug benefits even when participants are eligible for Medicare Part D benefits. Delta has determined that prescription drug coverage under the plans and options listed above is, on average for all plan participants, expected to pay out as much as standard Medicare Part D prescription drug coverage pays.

Therefore, the prescription drug coverage for these medical options is considered “Creditable Coverage” as defined by Medicare. This means that because your available Delta coverage under these options is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

What Creditable Coverage Options from Delta am I eligible for?

It depends on your job category, whether and when you retired, and other factors. Below is a summary of Delta creditable coverage options available for various groups of employees, dependents and retirees. You should check the Benefits Direct website for your exact options during Annual Open Enrollment:

- Active ground, and flight attendant employees age 65 and over and their eligible dependents have access to the Gold HSA or OOA Gold HSA and the HRA or OOA HRA options. Active Flight Dispatcher employees age 65 and over and their eligible dependents also have access to the FDMO or FDMO OOA option. Certain actively working SFO employees over age 65 also have access to the San Francisco Medical Option (but dependents are not eligible for this plan).
- Ground and flight attendant employees who are age 65 or older and their eligible dependents who are covered under Delta coverage when they

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retire or terminate are eligible for COBRA coverage under the Gold HSA or OOA Gold HSA options and the HRA or OOA HRA options for up to 18 months immediately following retirement or termination.

- Pre-merger Delta ground, flight attendant and Flight Dispatcher employees who retired before 2/1/2008 and are age 65 or older and their eligible dependents are eligible for the Standard Medical option or Standard Medical option (OOA) *only if* they have "lifetime COBRA" due to Delta's bankruptcy. If such retiree kept lifetime COBRA coverage in effect until his or her death, the retiree's spouse and eligible dependents remain eligible for COBRA under the Standard Medical option or Standard Medical option (OOA) for up to 36 months following the retiree's death.
- Pilot participants age 65 or over and their dependents who are covered under Delta coverage when they retire or terminate are eligible for COBRA coverage under the DPMP or DPMP OOA, the Gold HSA or OOA Gold HSA and the HRA or OOA HRA options for up to 18 months immediately following retirement or termination.
- Retired pilots age 65 or over who retired (i) prior to 12/31/2012 or (ii) on 1/1/2013 or later as part of the Pilot Retiree Medical Account (RMA) Program and (iii) the eligible dependents or survivors of pilots described in (i) or (ii) are eligible for the DPMP or DPMP OOA retiree coverage and, if they were pre-merger Delta pilot retirees who retired on or before 6/1/2006, the Standard Medical or Standard Medical Option OOA.
- Age 65+ survivors of a pilot who died before 1/1/2013 from active or disabled status are eligible for DPMP OOA retiree coverage.
- Pre-merger Northwest (PMNW) employees who went on inactive payroll status, including disability status, prior to the date their respective represented workgroup transitioned to Delta pay and benefits and remain inactive; eligible PMNW flight attendant, ground and flight dispatcher employees who retired after January 1, 2010 and prior to the date their respective represented workgroup transitioned to Delta pay and benefits; eligible survivors of these employees or retirees; and PMNW pilots who were inactive or disabled on the collective bargaining agreement implementation date (CBAID), October 30, 2008, and have not yet returned to active status or have retired since CBAID without returning to active status, as well survivors of such pilots or retirees who have died since CBAID are eligible for PPO Option B or PPO Option B OOA. Other participants who currently qualify for COBRA under any of the above listed plans or options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare Part D plan, you will still be eligible for Delta coverage at the next open enrollment as described in this Notice (Note: if you are a COBRA participant and drop Delta coverage, you may not reenroll in that coverage in the future). See **“What Should I Do Next?”** below for more information about what happens to your current coverage if you decide to join a Medicare prescription drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should know that if you drop or lose your current coverage with Delta and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without *creditable* prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

EXAMPLE: If you go nineteen months without creditable prescription drug coverage, your Medicare Part D premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

NON-CREDITABLE Prescription Drug Coverage Notice
(Applies to the Following Plans and Options)

- High Value Medical Option
- Silver Health Savings Account (HSA) Medical Option,
- Bronze HSA Medical Option
- Retiree & Survivor Bronze HSA Medical Option, and
- Retiree & Survivor Bronze OOA HSA Medical Option

The medical benefit options under the Delta health plans provide prescription drug benefits even when participants are eligible for Medicare Part D benefits. Delta has determined that the prescription drug coverage available under the options listed above is, on average for all plan participants enrolled in these options, NOT expected to pay out as much as the standard Medicare prescription drug coverage pays. Therefore, the prescription drug coverage for these options is considered "Non-Creditable Coverage" as defined by Medicare.

This is important, because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the High Value Medical Option, the Silver HSA Medical Option, the Bronze HSA Medical Option, the Retiree & Survivor Bronze HSA Medical Option or the Retiree & Survivor Bronze OOA HSA Medical Option. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare Part D drug plan when you first become eligible.

What Non-Creditable Coverage Options from Delta am I eligible for?

It depends on your job category, whether and when you retired, and other factors. Below is a summary of Delta non-creditable coverage options available for various groups of employees, dependents and retirees. You should check the Benefits Direct website for your exact options during Annual Open Enrollment:

- Active ground and flight attendant employees age 65 and over and their eligible dependents have access to the Silver HSA and the Bronze HSA options.
- Ground and flight attendant employees age 65 or older and their dependents enrolled in Delta coverage when they retire or terminate are eligible for COBRA coverage under the Silver and Bronze HSA options for up to 18 months immediately following retirement or termination.
- Ground, flight attendant and pilot employees who retire on or after 2/1/2008, and their eligible dependents and survivors are eligible for the Retiree & Survivor Bronze HSA or Retiree & Survivor Bronze OOA HSA option *until age 65*
- Pre-merger Delta ground and flight attendant employees who retired before 2/1/2008 and are 65 or older and their eligible dependents are eligible for the High Value option only if they have "lifetime COBRA" due to Delta's bankruptcy. If such retiree kept lifetime COBRA coverage in effect until his or her death, the retiree's spouse and eligible dependents remain eligible for COBRA under the High Value option for up to 36 months following the retiree's death.

- Pre-merger Delta retired pilots age 65 or over who retired on or before 6/1/2006 and their eligible dependents and survivors are eligible for the High Value option.
- Other participants who currently qualify for COBRA under any of the above listed options.

You can keep your current coverage under the High Value Medical Option, the Silver HSA Medical Option, the Bronze HSA Medical Option, the Retiree & Survivor Bronze HSA Medical Option or the Retiree & Survivor Bronze OOA HSA Medical Option. However, because this coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and the cost of the plans offering Medicare prescription drug coverage in your area. Read this Notice carefully – it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you decide to drop your current coverage with Delta, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under the High Value Medical Option, the Silver HSA Medical Option, the Bronze HSA Medical Option, the Retiree & Survivor Bronze HSA Medical Option or the Retiree & Survivor Bronze OOA HSA Medical Option.

If you are losing creditable prescription drug coverage under the Delta health plans, you are also eligible for a two (2) month SEP to join a Medicare drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

Since the coverage under the High Value Medical Option, the Silver HSA Medical Option, the Bronze HSA Medical Option, the Retiree & Survivor Bronze HSA Medical Option and the Retiree & Survivor Bronze OOA HSA Medical Option is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare Part D drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. Since being enrolled in the High Value Medical

Option, the Silver HSA Medical Option, the Bronze HSA Medical Option, Retiree & Survivor Bronze HSA Medical Option or the Retiree & Survivor Bronze OOA HSA Medical Option is equivalent to having no prescription drug coverage for purposes of this late enrollment penalty, then if you enroll in the High Value Medical Option or one of the HSA Medical Options (except for the Gold HSA and OOA Gold HSA Medical Options) but do not enroll in Medicare Part D during your initial open enrollment period, you will have to pay the higher Medicare Part D premium if you later enroll.

EXAMPLE: If you go nineteen months without creditable prescription drug coverage, your Medicare Part D premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare Part D plan, you will still be eligible for Delta coverage at the next open enrollment (unless you were enrolled in COBRA coverage and drop it). See “**What Should I Do Next?**” below for information about what happens to your current coverage if you decide to join a Medicare Part D drug plan.

What Should I Do Next?

Compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Part D prescription drug coverage in your area.

- If you are a (i) Medicare eligible active pilot employee; or (ii) a Medicare-eligible active ground or flight attendant employee; or (iii) a retiree who is eligible for Delta retiree coverage; or (iv) a Medicare eligible dependent of a person described in (i)-(iii) and you decide to enroll in a Medicare Part D plan and drop your Delta prescription drug coverage (which would also include dropping your medical coverage), be aware that you will not be able to elect to get Delta medical and prescription drug coverage back until the next annual enrollment period, to be effective the following January 1st. For instance, if you drop Delta coverage effective January 1, 2019, you will not be able to reenroll until January 1, 2020. If you or an eligible dependent are eligible for Delta COBRA coverage and decline enrollment in COBRA coverage or drop it during an enrollment, you will have waived your right to such COBRA coverage forever and cannot reinstate it at a later time.
- If you are not actively working (are retired or on disability) and decide to continue your Delta prescription drug coverage (including medical coverage) and then also enroll in a Medicare Part D plan, be aware that your Medicare

Part D plan will be your primary prescription drug coverage and your Delta coverage will be secondary to the Medicare Part D plan. However, your Delta medical option also covers health expenses in addition to prescription drugs, and you will still be eligible to receive health and prescription drug coverage secondary to Medicare, if you choose to enroll in a Medicare prescription drug plan and maintain your Delta medical benefit option as well. Remember the Delta medical benefits coordinate with Medicare Part A and Part B as they always have and the prescription drug benefit will coordinate such that it does not duplicate Medicare. If you are in an HSA option, enrolling in Medicare Part D will make you ineligible to contribute to a health savings account.

- If you are actively working and decide to continue your Delta prescription drug and medical coverage and also enroll in a Medicare Part D plan, the Delta plan pays primary to Medicare. However if you enroll in an HSA option, being enrolled in Medicare will make you ineligible to contribute to a Health Savings Account and your Delta Health Rewards dollars will be taxable.

To Learn More About the Medicare Part D Prescription Drug Plans or Your Delta Prescription Drug Coverage Access the Following Resources

Medicare Part D Prescription Drug Benefit

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook, available from Medicare. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans from these places:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048
- <http://www.medicare.gov>
- Your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number)

Certain people with limited resources and income may be able to receive extra help paying for Medicare prescription drug coverage. Contact the Social Security Administration for more information about this extra help by calling 1-800-772-1213 (TTY 1-800-325-0778) or visit them online at www.socialsecurity.gov

Delta Prescription Drug Benefit

For more information about your Delta prescription drug coverage (including pharmacy tiers, coinsurance and copays) under the Delta plans see the following:

- **Healthcare Benefits Handbook: Delta Account-Based Healthcare Plan (Other Than PPO Option B, PPO Option B Out-of-Area, FDMO Options, Dental Option B and FDMO Dental Options For Active, Inactive, COBRA and Certain Retiree**

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and Survivor Participants) (effective as of January 1, 2019) posted on *Benefits Direct* and on the *Benefits* page on *Deltanet*

- Healthcare Benefits Handbook: Delta Account-Based Healthcare Plan (Including PPO Option B, PPO Option B Out-of-Area and Dental Option B For Certain Active, Inactive, COBRA and Retiree and Survivor Participants) (effective as of January 1, 2019) posted on *Benefits Direct* and on the *Benefits* page on *Deltanet*

- Healthcare Benefits Handbook: Delta Pilots Medical Plan For Active, Inactive, COBRA and Certain Retiree and Survivor Pilot Participants (effective as of January 1, 2019) posted on *Benefits Direct* and on the *Benefits* page on *Deltanet*

- Healthcare Benefits Handbook: Flight Dispatchers Medical Option For Active, Inactive and COBRA Flight Dispatcher Participants (effective as of January 1, 2019) posted on *Benefits Direct* and on the *Benefits* page on *Deltanet*

- Healthcare Benefits Handbook: Delta Family-Care Medical Plan For Ground, Flight Attendant & Flight Dispatcher Retirees and Their Survivors whose retirement date was before 2/1/2008 and Pilot Retirees and Their Survivors whose retirement date was 06/01/2006 or earlier or who are disabled and their 60th Birthday was 06/01/2006 or earlier (effective as of January 01, 2019) posted on *Benefits Direct* and on the *Benefits* page on *Deltanet*

- <http://delta.welcometouhc.com/pharmacy-benefits> website to view the current UnitedHealthcare prescription drug list.

- UnitedHealthcare - Delta Health Direct- 1-877-912-1820

Note: You may receive this Notice at other times in the future, such as before the next Medicare Part D enrollment period, if this coverage changes, if new dependents are added to a participant's medical coverage and when a Delta employee is first eligible for medical coverage under the DPMP, San Francisco Medical Option and/or the DABHP. You may also request a copy of this notice at any time.

Date: October 1, 2018
 Name of Sender: Delta Air Lines, Inc.
 Contact: Delta Employee Service Center (ESC)
 Address: P.O. Box 52045 Phoenix, AZ 85072
 Phone Number: 800-MY-DELTA (1-800-693-3582)

Important Notice from Delta Air Lines, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it for future reference. We are required to send it to you if you and/or your eligible dependents are eligible for Medicare. This Notice has information about your current prescription drug coverage with Health Plan Hawaii and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This Notice also explains where to find more information to help you make a decision about your prescription drug coverage. If you enroll in a Medicare prescription drug plan, you may need to give a copy of this Notice when you join to show that you are not required to pay a higher premium amount.

What is Medicare Part D?

In 2006, Medicare prescription drug coverage became available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. These Medicare drug plans are commonly referred to as *Medicare Part D plans*. All Medicare drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Why am I getting this Notice?

In this Notice, Delta is required to give you certain information about the prescription drug coverage that you have under Health Plan Hawaii and how that coverage compares to the Medicare Part D coverage. Specifically, we have to inform you whether the prescription drug coverage under the Health Plan Hawaii HMO is "Creditable Coverage" or "Non-Creditable Coverage" and what that means to you and your Medicare Part D coverage.

Health Plan Hawaii HMO has determined that the prescription drug coverage offered by the Hawaii Medical Service Association (HMSA) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. This means that because your coverage under the Health Plan Hawaii HMO is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare Part D plan while you are an active employee, and drop your Health Plan Hawaii HMO prescription drug coverage, you will still be eligible to reenroll at the next open enrollment. (Note: if you are a COBRA participant and drop Health plan Hawaii HMO prescription drug coverage, you may not reenroll in that coverage in the future).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Health Plan Hawaii HMO and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact 1-800-776-4672. Please listen carefully to the menu options to ensure your call is directed appropriately.

NOTE: You may receive this Notice at other times in the future, such as before the next Medicare Part D enrollment period, if this coverage changes and if new dependents are added to a participant's medical coverage.

To Learn More About the Medicare Part D Prescription Drug Plans or Health Plan Hawaii Prescription Drug Coverage Access the Following Resources

Medicare Part D Prescription Drug Benefit

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Certain people with limited income and resources may be able to receive extra help paying for Medicare prescription drug coverage. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Health Plan Hawaii HMO Prescription Drug Benefit

For more information about your Health Plan Hawaii HMO prescription drug coverage (including pharmacy tiers, coinsurance and copays) see the **Healthcare Benefits Handbook** posted on *Benefits Direct* on *Deltanet*.

Date: October 1, 2018
 Name of Sender: Delta Air Lines, Inc.
 Name of Entity: Delta Employee Service Center (ESC)
 Address: PO Box 52045
 Phoenix, AZ 85072
 Phone Number: 1-800-MY-DELTA (1-800-693-3582)

Important Notice from Delta Air Lines, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it for future reference. We are required to send it to you if you and/or your eligible dependents are eligible for Medicare. This Notice has information about your current prescription drug coverage with Humana Health Plan of Puerto Rico and your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This Notice also explains where to find more information to help you make a decision about your prescription drug coverage. If you enroll in a Medicare prescription drug plan, you may need to give a copy of this Notice when you join to show that you are not required to pay a higher premium amount.

What is Medicare Part D?

In 2006, Medicare prescription drug coverage became available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. These Medicare drug plans are commonly referred to as *Medicare Part D plans*. All Medicare drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Why am I getting this Notice?

In this Notice, Delta is required to give you certain information about the prescription drug coverage that you have under Humana Health Plan of Puerto Rico and how that coverage compares to the Medicare Part D coverage. Specifically, we have to inform you whether the prescription drug coverage under the Humana Health Plan of Puerto Rico is “Creditable Coverage” or “Non-Creditable Coverage” and what that means to you and your Medicare Part D coverage.

Humana Health Plan of Puerto Rico has determined that the prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. This means that because your coverage under the Humana Health Plan of Puerto Rico is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare Part D plan while you are an active employee, and drop your Humana Health Plan of Puerto Rico prescription drug coverage, you will still be eligible to reenroll at the next open enrollment. (Note: if you are a COBRA participant and drop Humana Health plan of Puerto Rico prescription drug coverage, you may not reenroll in that coverage in the future).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Humana Health Plan of Puerto Rico and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact 1-800-776-4672. Please listen carefully to the menu options to ensure your call is directed appropriately.

NOTE: You may receive this Notice at other times in the future, such as before the next Medicare Part D enrollment period, if this coverage changes and if new dependents are added to a participant's medical coverage.

To Learn More About the Medicare Part D Prescription Drug Plans or Humana Health Plan of Puerto Rico Prescription Drug Coverage Access the Following Resources

Medicare Part D Prescription Drug Benefit

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Certain people with limited income and resources may be able to receive extra help paying for Medicare prescription drug coverage. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Humana Health Plan of Puerto Rico Prescription Drug Benefit

For more information about your Humana Health Plan of Puerto Rico prescription drug coverage (including pharmacy tiers, coinsurance and copays) see the **Healthcare Benefits Handbook** posted on *Benefits Direct* on *Deltanet*.

 Date: October 1, 2018
 Name of Sender: Delta Air Lines, Inc.
 Name of Entity: Delta Employee Service Center (ESC)
 Address: PO Box 52045
 Phoenix, AZ 85072
 Phone Number: 1-800-MY-DELTA (1-800-693-3582)

TERMS TO KNOW

TERMS TO KNOW

Account-Based Healthcare Plans

This type of plan generally has four parts:

- Paid Preventive Care
- A comprehensive medical plan that begins paying after you meet an annual Deductible
- Either a Health Reimbursement Account (HRA) or access to a Health Savings Account (HSA), and
- Tools and programs to help you manage your healthcare

Allowed Amount

The negotiated amount of payment that a Network Provider has agreed to accept as payment in full for a Covered Service at the time your claim is processed. Allowed Amount is also an amount determined by UnitedHealthcare (that may be lower than the provider's billed charges), unless a lower amount is negotiated or authorized by law for Covered Services performed by a Non-Network Provider for:

- An Emergency,
- When coordinated in advance by UHC, or
- Radiology, anesthesiology, pathology, lab or assistant surgeons and your Network Provider bills for them.

Annual Coinsurance Maximum

You have a separate Annual Coinsurance Maximum for network and non-network services under the DABHP options, other than the Out-of-Area (OOA) HRA and Retiree & Survivor Bronze OOA HSA Medical Options.

After you reach your network Coinsurance Maximum, the plan pays 100% of the Network Charges for the remainder of the year. After reaching the separate non-network Coinsurance Maximum, the plan pays 100% of 140% of the Medicare Reimbursement Rate (MNRP) for the remainder of the year. If any expenses are over 140% of the Medicare Reimbursement Rate, you pay 100% of that excess amount and it does not count toward Deductibles or the Annual Coinsurance Maximum.

For the OOA HRA Medical Option and Retiree & Survivor Bronze OOA HSA Medical Option, the plan pays 100% of R&C (or the Network Charge if a Network Provider is used) after the Coinsurance Maximum is met. If any expenses are over R&C, you pay 100% of that excess amount and it does not count toward Deductibles or the Annual Coinsurance Maximum.

The Annual Coinsurance Maximum is in addition to the Deductible in all of the HRA and HSA Medical Options; however, any amounts you are required to pay for amounts not covered under the plan (such as Tier 4 drugs, or failure to follow Prior Authorization requirements) do not apply to the Annual Coinsurance Maximum. Note: In the HRA and OOA HRA Medical Options, any prescription drug covered expense **does not** count toward the Annual Coinsurance Maximum; instead a separate Pharmacy Out-of-Pocket Maximum applies for these options.

Care Advocate

Care Advocates are responsible for case management and utilization review of behavioral health and substance abuse services, including authorization, concurrent review, and coordination and assurance of appropriate levels of care to members. Care Advocates provide case management services through review and evaluation of inpatient and outpatient behavioral health treatments for medical necessity, Emergency status, and quality of care. Care Advocates have a clinical license and have a Master's degree in counseling, psychology or social work or are registered nurses (RN) with psychiatry specialty. Care Advocates are employees or agents of the claims administrator, not Delta.

Coinsurance

Coinsurance is the amount of Covered Services to be paid by you, expressed as a percentage of the cost. For example, in an 80/20 plan, the plan pays 80% of a covered service and you pay the remaining 20%, which is the amount of the Coinsurance for which you are responsible, after the Deductible has been met.

Copay(ment)

A Copay is the fixed amount you pay directly to a Network Provider at the time you receive a Covered Service. Note that there are no Copays for medical services under the HRA and HSA Medical Options; however, you do pay a Copay for covered retail or mail order Tier 1 Preventive Drugs in the HRA and HSA Medical Options, and for covered prescription drugs in the Puerto Rico OOA Medical Option.

Covered Services

Covered Services are the health services, supplies, equipment or pharmaceutical products covered under the terms of your medical plan that are provided for the purpose of preventing, diagnosing or treating a sickness, injury, disease or symptom. They must be provided:

- When the plan is in effect;
- Before the date of the individual termination conditions set forth in the plan; and
- Only when the recipient is a covered person who meets all eligibility requirements specified in the plan

These supplies and services also must meet each of the following criteria:

- They are consistent with conclusions of prevailing medical research that demonstrate that the health services have a beneficial effect on health outcomes.
- They are the most cost-effective method that yields a similar outcome to other available alternatives
- They are health services, supplies or amounts that are not specifically excluded in any section of this handbook, including the "What the Delta Medical Plans Do Not Cover" in the "Medical Benefits" section of this handbook.

Custodial Care

Services that (1) do not require special skills or training and that provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating); (2) are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or (3) do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible

This term means slightly different things for different options.

For the HSA Medical Options and Puerto Rico Out-of-Area, the Deductible is the amount of money you must pay each calendar year for Network Covered Services or, separately, non-network Covered Services, before your medical plan begins to pay any of the charges (other than charges that are not subject to the Deductible, like Preventive Care and Preventive Drugs).

With the HRA Medical Options, the Deductible may not be an upfront cost to you like with the other options. In the HRA and OOA HRA Medical Options, covered medical expenses are paid automatically from available dollars in your HRA. Prescription drug expenses are not paid from your HRA and do not count toward the annual Deductible. If your medical expenses exceed the amount of HRA dollars you have, you must pay the remainder of the Deductible out of your pocket before the plan will pay anything else toward your covered expenses.

Coinsurance, as well as any amounts not covered under the plan (such as Tier 4 drugs, or failure to follow Prior Authorization requirements) does not count toward the Deductible.

Designated Facility

Designated Facilities are network centers of excellence and specialty centers that achieve high results and meet high quality of care standards for certain diseases or conditions.

Eligible Expense (Medical Benefits)

Eligible Expenses are the maximum allowable reimbursement rates for non-network or out-of-area services. UHC, as the Claims Administrator, has the discretion and authority to determine how the Eligible Expenses will be determined and otherwise covered under the Plan. The amount determined to be Eligible Expenses may be less than the actual amount charged by the doctor or supplier.

For details on how Eligible Expenses are determined, see the sections "Eligible Expenses for Non-Network Benefits" and "Eligible Expenses for Out-of-Area Benefits" in the "Medical Benefits" section of this handbook.

Expenses for services charged by a doctor or supplier over and above Eligible Expenses do not apply to an individual's Deductible or Annual Coinsurance Maximum Coinsurance Maximum, and are not paid by the plan. You pay 100% of this amount. Be aware that charges exceeding Eligible Expenses can double or triple what you may have assumed you would pay.

Eligible Expense (Flexible Spending Account)

An Eligible Expense is a healthcare or dependent care expense that the IRS considers reimbursable through an FSA. For a list of the type of expenses that may be considered Eligible Expenses for the Healthcare FSA, visit the IRS website at [irs.gov/pub/irs-pdf/p502.pdf](https://www.irs.gov/pub/irs-pdf/p502.pdf) or contact your local IRS office and ask for Publication 502. Remember that over-the-counter medications are not reimbursable from a Healthcare FSA unless they are prescribed by your physician. For a list of the type of expenses that may be considered Eligible Expenses for the Dependent Care FSA, visit the IRS website at [irs.gov/pub/irs-pdf/p503.pdf](https://www.irs.gov/pub/irs-pdf/p503.pdf) or contact your local IRS office to ask for Publication 503.

Note that only unreimbursed preventive care (e.g., services that do not meet the USPTF guidelines), vision and dental expenses are Eligible Expenses that may be reimbursed through the Limited Purpose Healthcare FSA until your annual medical Deductible under your HSA Medical Option is met. When your Deductible has been met for the year, you may also use the amounts in your Limited Purpose Healthcare FSA to reimburse qualified medical expenses you pay after reaching the Deductible and before you reach the Annual Coinsurance Maximum. The Limited Purpose Healthcare FSA is only offered to those employees who enroll in an HSA Medical Option. **Note:** If you have a Post-Deductible HRA in connection with your HSA Medical Option, it will automatically pay Eligible Expenses first after the minimum IRS deductible is met. Your Limited Purpose Healthcare FSA cannot be used to reimburse expenses until you pay for them out of pocket, which will be after your Post-Deductible HRA balance is zero and before your Annual Coinsurance Maximum is met.

Emergency

A true Emergency is a serious medical condition or symptom resulting from injury, sickness or mental illness, or substance use disorders which:

- Arises suddenly
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health
- If not treated immediately, could cause seriously impaired function, serious dysfunction of a bodily organ or part, or death, or in the case of pregnancy, serious jeopardy to the health of the fetus

In an Emergency, seek care immediately. You should call an ambulance or a police emergency number, or you should go directly to a hospital.

Healthcare Flexible Spending Account (FSA)

The Healthcare FSA is a tax-advantaged vehicle that is used to provide tax-free reimbursement for qualified healthcare expenses. You contribute pre-tax dollars, up to annual limits, which you can then use to pay for qualifying healthcare expenses incurred that year. Claims must be submitted by March 31st of the following year for reimbursement. As long as you continue to enroll in the Healthcare FSA, you may carry over up to \$500 of unused FSA funds each year; however, if you do not continue to enroll in the Healthcare FSA, the carryover funds must be used by the end of the plan year following the last year you participated in the Healthcare FSA.

There are two types of Healthcare FSAs available:

Full Purpose Healthcare FSA

You may participate in this type of FSA if you are enrolled in the HRA or OOA HRA Medical Option, or if you are enrolled in the "No Coverage" option. You can use your FSA funds to pay eligible medical, prescription drug, physician-prescribed over-the-counter medications and other eligible over-the-counter items, dental and vision expenses. For a list of the type of expenses that may be considered Eligible

Expenses for the Healthcare FSA, visit the IRS website at [irs.gov/pub/irs-pdf/p502.pdf](https://www.irs.gov/pub/irs-pdf/p502.pdf) or contact your local IRS office and ask for Publication 502.

Limited Purpose Healthcare FSA

If you enroll in the Gold HSA, OOA Gold HSA, Silver HSA or Bronze HSA Medical Option, your Limited Purpose Healthcare FSA works differently than a Full Purpose Healthcare FSA. Unreimbursed preventive care (e.g., services that do not meet the USTPF guidelines), vision and dental expenses are Eligible Expenses that may be reimbursed through the Limited Purpose FSA until your annual medical Deductible under your HSA Medical Option is met. When your Deductible has been met for the year, you may then also use the amounts in your Limited Purpose Healthcare FSA to reimburse qualified medical expenses you pay out of pocket after reaching the Deductible and before you reach the Annual Coinsurance Maximum.

Note: If you have a Post-Deductible HRA in connection with your HSA option, it will automatically pay Eligible Expenses first after the minimum IRS deductible is met. Your Limited Purpose Healthcare FSA cannot be used to reimburse expenses until *you* pay for them out of pocket, which will be after your Post-Deductible HRA balance is zero and before your Annual Coinsurance Maximum is met.

Health Reimbursement Account (HRA)

An HRA is a record-keeping account provided by Delta that is part of the HRA or OOA HRA Medical Option. It provides benefit dollars to be used to pay your eligible medical expenses that are subject to a Deductible or Coinsurance amount. Please note that prescription drug expenses are not paid from your HRA. If you remain continuously enrolled in a Delta HRA Medical Option, any account balance remaining in your HRA at the end of the year rolls over and is added to the next year's account balance.

Health Savings Account (HSA)

An HSA is an account permitted under federal tax law that allows you to save money for medical or pharmacy expenses on a tax-favored basis. Delta may also contribute to this account. The HSA belongs to you and is not part of your HSA Medical Option. It is portable, which means it is not tied to your employment at Delta. Your HSA stays with you if you retire or leave Delta. HSAs may earn interest or investment returns, based on the terms of the HSA. Because the HSA has a special tax-favored status under law, it is governed by numerous mandatory tax rules and regulations.

Medically Necessary

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, which are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice (as defined below);
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder, disease or its symptoms;
- Not mainly for your convenience or that of your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, mental illness, substance use disorder, disease or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time) are available to Plan participants on myuhc.com or by calling the number on your ID card.

Maximum Non-Network Reimbursement Program (MNRP)

The program uses a geographically-based reimbursement system (similar to R&C standards, and references rates and systems used by Medicare) that applies to non-Emergency charges of both physicians and facilities. Under the MNRP approach, reimbursement for non-network services is based on a percentage of the published rates allowed by Medicare (also known as the Medicare Reimbursement Rate).

Medicare Reimbursement Rate

The Medicare Reimbursement Rate is the amount a doctor or supplier is paid by Medicare, and it is the maximum allowable out-of-network reimbursement rate for non-network services, as established by the Maximum Non-Network Reimbursement Program (MNRP). It may be less than the actual amount charged by the doctor or supplier.

Expenses for services charged by a doctor or supplier over and above 140% of the Medicare Reimbursement Rates do not apply to an individual's Deductible or Coinsurance Maximum, and are not paid by the plan. You pay 100% of this amount. Be aware that charges exceeding 140% of the Medicare Reimbursement Rate can double or triple what you assumed you would pay.

Network Charges

Network Charges are the amount that a Network Provider has agreed to charge for Covered Services under a contract with the third-party administrator (for example, UHC). Network Charges that have been negotiated are discounted from the provider's standard charges and represent the reimbursable amount for a network service, as well as the amount on which your Coinsurance is based.

Network Providers

Network Providers are a group of healthcare professionals who have entered into a formal contract with a third-party administrator (such as UHC) to provide services and supplies at specified (negotiated) rates. When you use Network Providers, you generally are reimbursed at a higher rate for Covered Services and supplies than if you seek care from Non-Network Providers. Also, Network Providers generally submit your claims for you.

To obtain information about providers in UHC's network, access UHC's website at myuhc.com. You also can call the number on the back of your UHC ID card or use the UHC **Health4Me**™ mobile app for help finding the right doctor or hospital.

Non-Network Charges

Non-Network Charges are the amounts charged by a provider that does not participate in a network under a contract with a third-party administrator (such as UHC). Non-Network Charges are based on the allowable reimbursement rates determined by 140% of the Medicare Reimbursement Rate (see this term as it is defined earlier) or, for some options, on the Reasonable and Customary (R&C) charge (see this term as it is defined later) for services.

Non-Network Providers

Non-Network Providers do not participate in a network under a contract with a third-party administrator (such as UHC). When you use Non-Network Providers, you generally are reimbursed at a lower rate for Covered Services and supplies than if you seek care from Network Providers. Non-Network Providers are not responsible for submitting your claims or seeking Prior Authorization on your behalf.

Notification

You or your physician must contact UHC by calling Delta Health Direct within a certain amount of time after an emergency (non-elective) admission to a hospital. If you do not follow the Notification requirements of the plan, coverage for the supplies or services are not covered by the plan.

Out-of-Pocket Maximum

If you are enrolled in one of the HRA or HSA Medical Options, the Out-of-Pocket Maximum (OOP Max) is the most you will pay for covered medical and prescription drug expenses in a plan year before the plan pays 100% of your Eligible Expenses for the rest of the year. For the HSA Medical Options, the annual Out-of-Pocket Maximum includes the Deductible and Annual Coinsurance Maximum. For the HRA Medical Options, the annual Out-of-Pocket Maximum includes the Deductible, Annual Coinsurance Maximum for medical expenses and separate annual Pharmacy Out-of-Pocket Maximum. Expenses that are not covered by the plan such as Tier 4 prescription drugs and Prior Authorization penalties do not apply to the Out-of-Pocket Maximum and continue to be charged to the member after the Out-of-Pocket Maximum is met.

The Puerto Rico Out-of-Area (OOA) Medical Option includes an Out-of-Pocket Maximum (OOP Max). The OOP Max is the amount you have to pay per year before the plan begins to pay at a rate of 100%. Once you have paid the OOP Max amount, your medical plan pays 100% of your covered charges for the remainder of the year. The OOP Max excludes the Deductible in the Puerto Rico OOA Medical Option. In no event will the plan pay any amount over Eligible Expenses – R&C charges or over 140% of the Medicare Reimbursement Rates — those amounts are not covered by the Plan.

Pharmacy Out-Of-Pocket (OOP) Maximum

A separate Pharmacy OOP Maximum is a feature of the HRA Medical Option and the OOA HRA Medical Option. After you reach the Pharmacy OOP Maximum during the plan year, your medical option coverage pays all remaining eligible pharmacy expenses for the remainder of the year at 100%.

Post-Deductible HRA

If you are enrolled in a Delta HRA Medical Option and choose to enroll in an HSA Medical Option during a future enrollment period, including if you retire and enroll in the Retiree & Survivor Bronze HSA or Retiree & Survivor Bronze OOA HSA Medical Option, any HRA balance you have will become a Post-Deductible HRA.

A Post-Deductible HRA is used in conjunction with your HSA Medical Option. After you meet the IRS required minimum deductible for HSA plans, your Post-Deductible HRA will automatically begin to pay all your covered expenses until you either meet the HSA Medical Option's annual Deductible or your Post-Deductible HRA balance is zero. If you meet the HSA Medical Option's annual Deductible before your Post-Deductible HRA balance is exhausted, then it will automatically pay your Coinsurance until either you reach your Annual Coinsurance Maximum for the year or your Post-Deductible HRA balance is zero.

The Post-Deductible HRA does not replenish, and if you move out of the HSA Medical Option in the future, the Post-Deductible HRA will no longer be available even if you again become covered under a Delta HSA Medical Option in the future.

Pre-Existing Condition

Generally, a Pre-Existing Condition is a physical or mental condition that you or an eligible dependent received treatment for, or was diagnosed with, before coverage under a plan begins. The Delta healthcare plans cover eligible expenses for a Pre-Existing Condition the same as for any other medical condition.

Premium (Employee Contribution)

The Premium (Employee Contribution) is your cost to have health coverage through Delta. These costs are generally deducted from your paycheck or benefit payment (for those receiving pension or disability benefits).

Preventive Care

Participants are eligible to receive certain Preventive Care services, based on age, gender and other factors, with no cost-sharing (Coinsurance and Deductibles). For participants in the HRA, Gold HSA, Silver HSA, Bronze HSA or Retiree & Survivor Bronze HSA, the services must be rendered by physicians and other health care professionals who participate in the plan's network in order to be covered at 100%. If you are seeking Preventive Care and are unable to find a Network Provider, visit myuhc.com or contact Delta Health Direct at **877-912-1820** for assistance. If through this process of working with UnitedHealthcare, you collaboratively cannot locate a Network Provider to perform a Preventive Care service, the plan is required to cover that visit at 100%. *Understand that in this situation, however, you need to contact UHC **before** going to the doctor for your Preventive Care visit to confirm if it will be covered by the plan; there is no guarantee of payment otherwise.*

The Delta Account-Based Healthcare Plan options cover Preventive Care services in accordance with U.S. Preventive Services Task Force (USPSTF) Grade A and B guidelines, the Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for preventive services for

women, infants, children and adolescents, and the Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC).

For further details on your Preventive Care coverage, refer to the “Medical Benefits” section of this handbook:

- “Preventive Care” in the “Key Features of the DABHP Medical Options” section
- Your respective plan’s Covered Services chart
- “Preventive Care – Routine Physicals, Women’s Preventive Services, Annual Colonoscopies, and Well Child Visits” in the “What The Delta Medical Plans Cover” section

Preventive Drugs

Preventive Drugs are those prescribed to prevent the occurrence of a disease or condition for those individuals with risk factors, or to prevent the recurrence of a disease or condition for those who have recovered. Preventive Drugs may be those used for the prevention of conditions such as high blood pressure, high cholesterol, osteoporosis, heart attack, and prenatal nutrient deficiency. Your share of the cost for Preventive Drugs applies toward your Annual Coinsurance Maximum, but do not apply toward your annual Deductible

Primary Care Physician

A Primary Care Physician (PCP) is a general practitioner, internist or pediatrician who acts as your family doctor. Your PCP is responsible for overseeing and coordinating your care with other healthcare providers. You are not required to select a PCP or to notify UHC of your PCP selection.

Prior Authorization

You or your physician must contact UHC by calling Delta Health Direct within a certain amount of time before you receive certain supplies or services. As required for behavioral health or substance use treatment, you or your physician must notify OptumHealth Behavioral Solutions. After UHC or OptumHealth Behavioral Solutions receives notice, it determines if the service or supply is a Medically Necessary Covered Service. If you do not follow the Prior Authorization requirements of the plan, coverage for the supplies or services are not covered by the plan. Or, if you choose to receive a service that has been determined not to be a Medically Necessary Covered Service and therefore is not authorized, the service is not covered under the plan.

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that directs the Plan Administrator to cover a child for benefits under the medical, dental or vision plans. A QMCSO may be issued in a divorce or legal separation proceeding, and may require you to provide healthcare coverage for a child who is not in your custody. The plans have specific rules and procedures that a QMCSO must meet. Among them, a QMCSO may not require the plans to provide coverage for any type or form of benefit not otherwise provided under the plans. Although the plans’ usual enrollment deadlines do not apply in the case of a QMCSO, you must notify the Employee Service Center (ESC) and enroll your child as soon as reasonably possible.

Reasonable and Customary (R&C) – Medical

The Reasonable and Customary (R&C) charge is based on the amount charged by providers for the same service or supply in the same geographic area where the service is received. You are required to pay 100% of the cost above what is determined to be Reasonable and Customary.

For services or supplies other than Pharmaceutical Products*, a charge is Reasonable and Customary if it is not more than the normal charge for comparable treatment, services or supplies by doctors, or other providers of medical services, in the same geographic area, as determined by the claims administrator. Charges for Covered Services are based on either the negotiated rates agreed to by the Non-Network Provider or on competitive fees in that geographic area. If no fee information is available, the R&C charge is based on 50% of the billed charges, except certain Eligible Expenses for behavioral health and substance abuse are based on 80% of the billed charge.

For Pharmaceutical Products covered under your medical benefits, the Reasonable and Customary charge is based on 100% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within a geographic market. When a rate is not published by CMS for the service, UHC will use the gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price of the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomas Reuters* (published in its Red Book) or UHC based on internally developed pharmaceutical pricing resources.

Amounts over R&C charge limits are not covered expenses under the plan and do not count toward the plan's Deductible or Annual Coinsurance Maximums/Out-of-Pocket Maximums. You must pay 100% of any amounts over Reasonable and Customary charges in addition to any other costs that are your responsibility.

Reasonable and Customary (R&C) – Dental

Benefit payment for dental care, treatment, services and supplies provided by non-participating dentists are based on Reasonable and Customary (R&C) charges. R&C is calculated based on the lowest of 1) the dentist's actual charge, 2) the dentist's usual charge for the same or similar services, or 3) the usual charge of most dentists in the same geographic area for the same or similar services, as determined by the claims administrator (MetLife). Amounts over the R&C charge limits are not covered under the plan – you must pay 100% of those amounts. In addition, amounts over R&C charge limits do not count toward your Deductible.

Spouse

Your Spouse is the person you are legally married to under the laws of the state in which you were married, regardless of your state of residence. Individuals in registered domestic partnerships, civil unions, and common law marriages are not considered Spouses under the Plan.

* Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Service by a physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the plan.

WHERE TO GET MORE INFORMATION

HEALTHCARE BENEFITS HANDBOOK

WHERE TO GET MORE INFORMATION

If you have questions about the information in this handbook, contact the vendors listed below. You can find additional frequently called phone numbers on Deltanet (<https://deltanet.delta.com>).

Benefits Contact Information	
Benefit Type	Contact
<p>Medical</p> <ul style="list-style-type: none"> • Delta Account-Based Healthcare Plan (DABHP) <ul style="list-style-type: none"> – HRA Medical Option, OOA HRA Medical Option, Gold HSA Medical Option, OOA Gold HSA Medical Option, Silver HSA Medical Option, Bronze HSA Medical Option, Retiree & Survivor Bronze HSA Medical Option, Retiree & Survivor Bronze OOA HSA Medical Option, Puerto Rico OOA Medical Option • Health Plan Hawaii • Humana Health Plan of Puerto Rico 	<p>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 Delta Health Direct: 877-912-1820 www.myuhc.com</p> <p>Hawaii Medical Service Association 818 Keeaumoku Street Honolulu, HI 96814 Current Members: 808-948-6372 Prospective Members: 808-948-6111 www.hmsa.com</p> <p>Humana Health Plan of Puerto Rico Edificio El Mundo 3er. Piso 383 Ave F D Roosevelt San Juan, Puerto Rico 00918-2131 787-282-7900 ext. 5500 www.humana.com</p>
<p>Dental</p> <ul style="list-style-type: none"> • DABHP <ul style="list-style-type: none"> – Basic Dental Option – Comprehensive Dental Option 	<p>MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 855-700-7992 Fax: 1-859-389-6505 www.metlife.com/mybenefits (company name "Delta Air Lines")</p>
<p>Vision</p>	<p>First American Administrators Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 833 DELTA VP (833-335-8287) www.eyemedvisioncare.com</p>

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Benefits Contact Information	
Benefit Type	Contact
Flexible Spending Accounts (FSAs) <ul style="list-style-type: none"> • Full Purpose Healthcare FSA • Limited Purpose Healthcare FSA • Dependent Care FSA 	UnitedHealthcare Member Services P.O. Box 981506 El Paso, TX 79998-1506 Delta Health Direct: 877-912-1820 Fax: 915-231-1709 Toll-free fax: 866-262-6354 www.myuhc.com
COBRA Continuation Benefits <ul style="list-style-type: none"> • Medical Options • Dental Options • EyeMed Vision Plan • Full Purpose Healthcare FSA • Limited Purpose Healthcare FSA 	Employee Service Center (ESC): 1-800 MY DELTA (1-800-693-3582) For correspondence only: Delta Employee Service Center P.O. Box 52045 Phoenix, AZ 85072 For COBRA Premium payments only: Conduent HR Services LLC for Delta Air Lines P.O. Box 382119 Pittsburgh, PA 15251-8119
Delta Employee Assistance Program (EAP)	OptumHealth Behavioral Solutions 800-533-6939 www.liveandworkwell.com (Access Code: DAL)
Eligibility and Enrollment Issues Qualified Life Events	Delta Air Lines, Inc. Employee Service Center P.O. Box 52045 Phoenix, AZ 85072 1-800 MY DELTA (1-800-693-3582)
Health Savings Account – Optum BankSM	Optum Bank SM P.O. Box 271629 Salt Lake City, UT 84127-1629 For questions about the Optum Bank HSA, contact a Optum Bank customer service representative: 800-791-9361 www.optumbank.com For questions about HSA payroll deductions, call the ESC: 1-800 MY DELTA (1-800-693-3582)
Direct Bill/Premium Payments	For questions about Direct Bill/Premium payments, call the ESC: 1-800 MY DELTA (1-800-693-3582) Send all Direct Bill/Premium payments to: Conduent HR Services LLC for Delta Air Lines P.O. Box 382119 Pittsburgh, PA 15251-8119

EXHIBIT 11

Summary Plan Description

Dollar Tree Management, Inc. Bronze Plan

Effective: January 1, 2019
Group Number: 752495

Amended: June 1, 2019



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SECTION 1 - WELCOME**Quick Reference Box**

- For any support call: (888) 355-2509;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, Georgia 30374-0800; and
- Online assistance: www.myuhc.com.

Dollar Tree Management, Inc. is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Dollar Tree Management, Inc. Group Health Benefit Plan. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Dollar Tree Management, Inc. intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Dollar Tree Management, Inc. is solely responsible for paying Benefits described in this SPD.

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

Please read this SPD thoroughly to learn how the Dollar Tree Management, Inc. Group Health Benefit Plan works. If you have questions contact mytree Support Center or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.mytree.hrintouch.com or request printed copies by contacting the mytree Support Center.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Dollar Tree Management, Inc. is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular Employee who is scheduled to work at least 30 or more hours per week.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- you or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Dollar Tree Management, Inc. Group Health Benefit Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Dollar Tree Management, Inc. Group Health Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Dollar Tree Management, Inc. share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Dollar Tree Management, Inc. reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling mytree Support Center at 1-855-245-7994 or logging onto www.mytree.hrntouch.com.

How to Enroll

To enroll, log onto www.mytree.hrntouch.com during the time period specified in your enrollment paperwork. If you do not enroll during the specified time period, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following a qualified status change (Ex: your marriage, birth, adoption of a child, placement for adoption of a child or other family status change), you must contact mytree Support Center within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once mytree Support Center receives your properly completed enrollment, coverage will begin on the first day of the month on or after 60 days of employment. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner and provided the necessary documentation to support their status as a dependent.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date mytree Support Center receives notice of your marriage, provided you notify mytree Support Center within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify mytree Support Center within 31 days of the birth, adoption, or placement. Newborns are not automatically covered within the first 31 days. You have within 31 days to enroll the newborn. If enrolled timely coverage will go retroactive to the date of birth. Claims received prior to newborn enrollment will be denied. If enrolled within allotted timeframe, claims will be adjusted.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment resulting in involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact mytree Support Center within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact mytree Support Center within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact mytree Support Center within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Dollar Tree Management, Inc.'s medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Dollar Tree Management, Inc.'s medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Dollar Tree Management, Inc. or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

Dollar Tree Management, Inc. has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. Non-Network providers are not contractually limited as to how much they can charge for their services and can balance bill you for any amounts above the Eligible Expense amounts covered by your Plan. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - ◆ For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
 - ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, UnitedHealthcare uses a

gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card

Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 60% after you meet the Annual Deductible, you are responsible for paying the other 40%. This 40% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance for Covered Health Services available in Section 15, <i>Outpatient Prescription Drugs</i>	Yes	Yes
Charges for non-Covered Health Services	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support-Total Population (PHS-TP). It delivers comprehensive, personalized care and services to you and your covered Dependents. You can engage with your PHS-TP care team by calling the toll-free number listed on the back of your ID card.

PHS-TP Nurses and Coaches center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective health and wellness services available.

If you are living with a chronic condition, dealing with complex health care needs, would like help improving your health or simply have questions, you can work with a nurse or wellness coach who will guide you through your healthcare journey. The nurse or coach will answer questions, explain options, identify your needs, and may refer you to specialized care programs. When you work with a nurse or coach, they will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

PHS-TP provides comprehensive set of services to help you and your covered family members access information and receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the program includes, but is not limited to, items such as:

- **Admission counseling** - PHS-TP Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a PHS-TP Nurse to confirm that medications, needed equipment, or follow-up services are in place. The PHS-TP Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a PHS-TP Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a PHS-TP Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Note: If you have a medical emergency, call 911 instead of calling your PHS-TP care team.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section 6, *Additional Coverage Details*.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Contacting UnitedHealthcare or Personal Health Support is easy.

Simply call the number on your ID card.

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 6, *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Copays¹		
<ul style="list-style-type: none"> ■ Physician's Office Services - Primary Physician 	\$50	*40% after you meet the Annual Deductible
<ul style="list-style-type: none"> ■ Physician's Office Services - Specialist 	\$85	*40% after you meet the Annual Deductible
<ul style="list-style-type: none"> ■ Urgent Care Center Services 	\$85	*40% after you meet the Annual Deductible
<ul style="list-style-type: none"> ■ Virtual Visits 	\$50	Not Applicable
Annual Deductible²		
<ul style="list-style-type: none"> ■ Individual 	\$3,500	\$6,000
<ul style="list-style-type: none"> ■ Family (not to exceed the applicable Individual amount per Covered Person) 	\$7,000	\$12,000
<p>The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, <i>Outpatient Prescription Drugs</i>.</p>		
Annual Out-of-Pocket Maximum²		
<ul style="list-style-type: none"> ■ Individual 	\$6,250	\$12,500
<ul style="list-style-type: none"> ■ Family (not to exceed the applicable Individual amount per Covered Person) 	\$12,500	\$25,000
<p>The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, <i>Outpatient Prescription Drugs</i>.</p>		

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Plan Features	Network	Non-Network
<p>Lifetime Maximum Benefit³ There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</p>	<p>Unlimited</p>	

*Balance billing applies.

¹In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.

²Copays apply toward the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

³Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Allergy Care (injections, antigens/serum)	Physician's Office Services (when no Physician's office charged), 100% All other services, 60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Ambulance Services <ul style="list-style-type: none"> ■ Emergency Ambulance ■ Non-Emergency Ambulance 	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible	60% after you meet the Annual Deductible 40% after you meet the Annual Deductible
Cancer Services For Network Benefits, oncology services must be received by a Designated Provider. See <i>Cancer Resource Services (CRS)</i> in Section 6, <i>Additional Coverage Details</i> .	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<p>Cellular and Gene Therapy</p> <p>Services must be received at a Designated Provider.</p>	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available.
<p>Clinical Trial</p> <p>Non-Network Benefits include services provided at a Network facility that is not a Designated Provider and services provided at a non-Network facility.</p>	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
<p>Congenital Heart Disease (CHD) Surgeries</p> <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay 	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
<p>Dental Services - Accident Only</p> <ul style="list-style-type: none"> ■ Primary Physician (Copay is per visit) ■ Specialist Physician (Copay is per visit) 	100% after you pay a \$50 Copay 100% after you pay a \$85 Copay	40% after you meet the Annual Deductible
<p>Diabetes Services</p> <p>Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> in this section and in Section 15, <i>Outpatient</i></p>	

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
	<i>Prescription Drugs.</i>	
Durable Medical Equipment (DME)	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Emergency Health Services - Outpatient	60% after you meet the Annual Deductible	
Family Planning	100%	100%
Foot Care	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Home Health Care Unlimited visits with each visit at a 16-hour day maximum.	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospice Care	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospital - Inpatient Stay	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<p>Kidney Services</p> <p>For Network Benefits, kidney services must be received by a Designated Provider.</p> <p>See <i>Kidney Resource Services (KRS)</i> in Section 6, <i>Additional Coverage Details</i>.</p>	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<p>Lab, X-Ray and Diagnostics - Outpatient</p>	<p>Prostate-Specific Antigen (PSA) screening, 100%</p> <p>All other services, 60% after you meet the Annual Deductible</p>	40% after you meet the Annual Deductible
<p>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</p>	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
<p>Mental Health Services</p> <ul style="list-style-type: none"> ■ Inpatient 	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> ■ Outpatient (Copay is per visit) 	<p>100% after you pay a \$50 Copay</p> <p>60% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</p>	<p>40% after you meet the Annual Deductible</p> <p>40% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</p>
<p>Neonatal Services</p> <p>For Network Benefits, neonatal services must be received by a Designated Provider.</p> <p>See <i>Neonatal Resource Services (NRS)</i> in Section 6, <i>Additional Coverage Details</i>.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</p>
<p>Neurobiological Disorders - Autism Spectrum Disorder Services</p> <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient (Copay is per visit) 	<p>60% after you meet the Annual Deductible</p> <p>100% after you pay a \$50 Copay</p> <p>60% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</p>	<p>40% after you meet the Annual Deductible</p> <p>40% after you meet the Annual Deductible</p> <p>40% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</p>

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<p>Nutritional Counseling</p> <ul style="list-style-type: none"> ■ Primary Physician (Copay is per visit) ■ Specialist Physician (Copay is per visit) <p>Up to three visits per Covered Person per condition per lifetime</p>	<p>100% after you pay a \$50 Copay</p> <p>100% after you pay a \$85 Copay</p>	<p>40% after you meet the Annual Deductible</p>
<p>Orthognathic Surgery (Copay is per visit)</p>	<p>100% after you pay a \$50 Copay</p>	<p>40% after you meet the Annual Deductible</p>
<p>Ostomy Supplies</p>	<p>60% after you meet the Annual Deductible</p>	<p>40% after you meet the Annual Deductible</p>
<p>Pharmaceutical Products - Outpatient</p>	<p>60% after you meet the Annual Deductible</p>	<p>40% after you meet the Annual Deductible</p>
<p>Physician Fees for Surgical and Medical Services</p>	<p>60% after you meet the Annual Deductible</p>	<p>40% after you meet the Annual Deductible</p>
<p>Physician's Office Services - Sickness and Injury</p> <ul style="list-style-type: none"> ■ Primary Physician (Copay is per visit) ■ Specialist Physician (Copay is per visit) <p>In addition to the Copay stated in this section, the Copays, Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> ■ lab, radiology/x-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics – Outpatient</i>; ■ major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major</i> 	<p>100% after you pay a \$50 Copay</p> <p>100% after you pay a \$85 Copay</p>	<p>40% after you meet the Annual Deductible</p> <p>40% after you meet the Annual Deductible</p>

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> ■ Breast Pumps 	100%	40% after you meet the Annual Deductible
<p>Private Duty Nursing - Outpatient Up to 30 visits per Covered Person per calendar year</p>	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Prosthetic Devices	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
<p>Reconstructive Procedures</p> <ul style="list-style-type: none"> ■ Primary Physician (Copay is per visit) ■ Specialist Physician (Copay is per visit) ■ Hospital - Inpatient Stay ■ Physician Fees for Surgical and Medical Services 	<p>100% after you pay a \$50 Copay</p> <p>100% after you pay a \$85 Copay</p> <p>60% after you meet the Annual Deductible</p> <p>60% after you meet the Annual</p>	<p>40% after you meet the Annual Deductible</p> <p>40% after you meet the Annual Deductible</p> <p>40% after you meet the Annual Deductible</p> <p>40% after you meet the Annual</p>

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> ■ Prosthetic Devices 	Deductible 60% after you meet the Annual Deductible	Deductible 40% after you meet the Annual Deductible

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> ■ Surgery – Outpatient (Surgery in physician’s office at 100% after you pay a \$50 Copay) 	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
<p>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Copay is per visit)</p> <ul style="list-style-type: none"> ■ Primary Physician (Copay is per visit) ■ Specialist Physician (Copay is per visit) <p>See Section 6, Additional Coverage Details, for visit limits</p>	<p>Manipulative Treatment, 100% after you pay a \$85 Copay</p> <p>All other services, 100% after you pay a \$50 Copay</p> <p>100% after you pay a \$85 Copay</p>	40% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
<p>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 100 days maximum per Covered Person per confinement</p>	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
<p>Substance-Related and Addictive Disorders Services</p> <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient (Copay is per visit) 	<p>60% after you meet the Annual Deductible</p> <p>100% after you pay a \$50 Copay</p> <p>60% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</p>	<p>40% after you meet the Annual Deductible</p> <p>40% after you meet the Annual Deductible</p> <p>40% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible</p>

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Surgery - Outpatient (Surgery in physician's office at 100% after you pay a \$50 Copay)	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services (Copay is per visit)	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient	Dialysis, 60% after you meet the Annual Deductible All other services, 60% after you meet the Annual Deductible	Dialysis, Not Covered All other services, 40% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Provider)	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.	Non-Network Benefits are not available
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing cancer treatment, Congenital Heart Disease treatment or transplant procedures	

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<p>Urgent Care Center Services (Copay is per visit)</p> <p>In addition to the Copay stated in this section, the Copays, Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> ■ lab, radiology/x-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>; ■ major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>; ■ diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>; ■ outpatient surgery procedures described under <i>Surgery - Outpatient</i>; ■ outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>; and ■ rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</i>. 	100% after you pay a \$85 Copay	40% after you meet the Annual Deductible
<p>Virtual Visits</p> <p>Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.</p>	100% after you pay a \$50 Copay	Non-Network Benefits are not available.

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Wigs Up to one per Covered Person per calendar year	60% after you meet the Annual Deductible	40% after you meet the Annual Deductible

¹Please obtain prior authorization from the Claims Administrator before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that for which you should obtain prior authorization before you receive them.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Allergy Care (injections, antigens, serum)

Benefits for allergy care are covered. Network Benefits are paid at 100% no Deductible (no Copay) when billed without a physician exam in Physician's office.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

The Plan does not cover ambulance transportation from the Hospital to home.

Prior Authorization Requirement

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain prior authorization as soon as possible before transport.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury.*
- *Physician Fees for Surgical and Medical Services.*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*
- *Therapeutic Treatments - Outpatient.*
- *Hospital - Inpatient Stay.*
- *Surgery - Outpatient.*

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received by a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Prior Authorization Requirement

For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - certain Category B devices;
 - certain promising interventions for patients with terminal illnesses; and
 - other items and services that meet specified criteria in accordance with our medical and drug policies;

- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*);
 - *Centers for Disease Control and Prevention (CDC)*;
 - *Agency for Healthcare Research and Quality (AHRQ)*;
 - *Centers for Medicare and Medicaid Services (CMS)*;
 - a cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
 - a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - ◆ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or

- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement

You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;

- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Prior Authorization Requirement

For Covered Health Services required to be received by a Designated Provider, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD surgeries are not received by a Designated Provider, Network Benefits will not be paid, Non-Network Benefits will apply.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

"Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury or within 12 months of the Member's Effective Date. Treatment must be completed within 24 months of the initial treatment.

The Plan includes Benefits for dental work required for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an accidental injury.

The \$900/tooth/\$3,000 annual maximum does not apply to accidental dental.

The Plan also includes Benefits for Hospital charges and anesthetics provided for dental care if the member meets any of the following conditions:

- the member is under age of five (5);
- the member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- the member has a medical condition that requires hospitalization or general anesthesia for dental care.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Outpatient Prescription Drugs*.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME for the management and treatment of diabetes that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item).

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- Shoe inserts, orthotics (except when prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary);
- custom molded cranial orthotics (helmets), when prescribed by Physician;
- rthopedic shoes (except when an orthopedic shoe is joined to a brace) are not covered;

- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Supplies dispensed by a physician and/or supply house are covered under the medical plan. Benefits subject to applicable deductible/coinsurance.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item).

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network

Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Family Planning

Benefits for family planning covers sterilization, Depo-Provera, Norplant, diaphragm, IUD and therapeutic abortions to save the life or health of the mother, or as a result of incest or rape.

Foot Care

The Plan will cover foot care when required as part of the treatment of diabetes and for members with impaired circulation to the lower extremities.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are unlimited with each visit at a 16-hour day maximum. (Does not apply to Private Duty Nursing benefit)

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods and Private Duty Nursing, or as soon as is reasonably possible.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while

the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

The Hospice treatment program must:

- be recognized as an approved Hospice program by the Claims Administrator;
- include support services to help covered family members deal with the Member's death; and
- be directed by a Physician and coordinated by an RN with a treatment plan that:
 - provides an organized system of home care;
 - uses a Hospice team; and
 - has around-the-clock care available.

To qualify for Hospice care, the attending Physician must certify that the member is not expected to live more than six months. Also, the Physician must design and recommend a Hospice Care Program.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement

For Non-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support; or
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- lab and radiology/x-ray;
- mammography; and
- Prostate-Specific Antigen (PSA) screening.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Benefits include PSA screenings. Preventive screenings that have in effect a rating of “A” or “B” in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per Covered Person per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per Covered Person per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement

For Non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Methadone clinics for inpatient and outpatient services.
- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claim Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Providers participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Provider is defined in Section 14, *Glossary*.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator or Personal Health Support.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to three individual sessions in your lifetime for each medical condition. This limit applies to non-preventive nutritional counseling services only.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Orthognathic Surgery

Benefits for orthognathic surgery are limited to:

- removal of impacted teeth;
- fracture of facial bones;
- lesions of the mouth, lip, or tongue which require a pathological exam;
- incision of accessory sinuses, mouth salivary glands or ducts;
- dislocations of the jaw;

- plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments.

The Plan also includes benefits for hospital charges and anesthetics provided for dental care if the member meets any of the following conditions:

- the member is under the age of five (5);
- the member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- the member has a medical condition that requires hospitalization or general anesthesia for dental care.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters;
- urinary catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional.

Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Christian Science Practitioners are not covered.

Naturopaths are covered same as any other office visit/provider.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

Prior Authorization Requirement

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA is performed.

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Healthy Pregnancy Program

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

First screening each calendar year for colorectal cancer and mammography are considered preventive regardless of diagnosis. All subsequent colorectal cancer and mammography screenings in the calendar year pay at plan level.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Any combination of Network Benefits and Non-Network Benefits is limited to 30 visits per Covered Person per calendar year.

Prosthetic Devices

- Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician. Prosthetic devices include: artificial limbs and accessories;
- artificial eyes one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s);
- arm braces, leg braces (and attached shoes);
- and external breast prosthesis used following mastectomy.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

Benefits do not include:

- corrective shoes;
- dentures;
- replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries;
- electrical or magnetic continence aids (either anal or urethral); and
- implants for cosmetic purposes except for reconstruction following a mastectomy.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year

timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceeds \$1,000 in cost per device.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- physical therapy;
- occupational therapy;
- manipulative treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- vision therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

Benefits are limited to:

- 30 visits per Covered Person per calendar year for physical and occupational therapy combined;
- 30 visits per Covered Person per calendar year for speech therapy; and
- 15 visits per Covered Person per calendar year for Manipulative Treatment.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 days maximum per Covered Person per confinement.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Methadone clinics for inpatient and outpatient services.
- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization Requirement

For Non-Network Benefits for blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgery, cochlear implant and orthognathic surgeries you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician.

Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

The Plan covers treatment of temporomandibular joint syndrome (TMJ) or myofacial pain includes only removable appliances for TMJ repositioning when related surgery and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement

For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Prior Authorization Requirement

For Network Benefits you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed by a Designated Provider, Network Benefits will not be paid.

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care by a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.

- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of \$10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to \$50.00 per day, for the patient (when not in the Hospital) or the caregiver.
- Per diem is limited to \$100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.

- Tolls.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for a Covered Health Service.

Benefits for wigs are limited to 1 per Covered Person per calendar year (subject to Medical Necessity).

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Dollar Tree Management, Inc. believes in giving you the tools you need to be an educated health care consumer. To that end, Dollar Tree Management, Inc. has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Dollar Tree Management, Inc. are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Survey

You, your Spouse and Dependents older than 18 are invited to learn more about your health and wellness at www.myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to www.myuhc.com. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Dollar Tree Management, Inc.'s way of helping you meet your health and wellness goals.

NurseLineSM

NurseLineSM is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Dollar Tree Management, Inc. has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLineSM gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLineSM is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

With NurseLineSM, you also have access to nurses online. To use this service, log onto www.myuhc.com and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto www.myuhc.com.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer; and
- coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and

- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (866) 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - education about the specific disease and condition,
 - medication management and compliance,
 - reinforcement of on-line behavior modification program goals,
 - preparation and support for upcoming Physician visits,
 - review of psychosocial services and community resources,

- caregiver status and in-home safety,
- use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealthNotesSM

UnitedHealthcare provides a service called HealthNotes to help educate members and make suggestions regarding your medical care. HealthNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealthNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealthNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Back Program

UnitedHealthcare provides a program that identifies, assesses, and supports members with acute and chronic back conditions. By participating in this program you may receive free educational information through the mail and may even be called by a registered nurse who is a specialist in acute and chronic back conditions. This nurse will be a resource to advise and help you manage your condition.

This program offers:

- Education on back-related information and self-care strategies.
- Management of depression related to chronic back pain.
- Support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Healthy Weight Program

UnitedHealthcare provides a non-surgical approach to addressing weight and obesity through nutritional and activity guidance. The program is designed to support you. This means that you may receive free educational information on the web or through the mail and may even be called by a health coach who is a specialist in weight management. This health coach will be a resource to advise and help you manage your weight.

This program offers:

- on-line self-help tools: health assessment, exercise tracker, meal planner, calorie counter and educational content;
- education on weight management and self-care strategies;
- nutritional guidance and counseling by a health coach and registered dietician (if needed); and
- activity recommendations and encouragement by a health coach and exercise physiologist (if needed).

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit www.realappeal.com.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life[®] program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life[®] program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach[®] staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life[®], or if you would like additional information regarding the program and also how to access the program online, please call the number on the back of your ID card.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. acupuncture;
3. aromatherapy;
4. hypnotism;
5. massage therapy;
6. Roling (holistic tissue massage); and
7. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

- extractions (excluding wisdom teeth);
- restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; and
- services to improve dental clinical outcomes;

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants, bone grafts, and other implant-related procedures;

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);
5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*;

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

3. the following items are excluded, even if prescribed by a Physician:
 - blood pressure cuff/monitor;
 - enuresis alarm;
 - non-wearable external defibrillator;
 - trusses;

- ultrasonic nebulizers;
- 4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;
- 5. the replacement of lost or stolen prosthetic devices;
- 6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*;
- 7. oral appliances for snoring.

Drugs

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);
3. growth hormone therapy;
4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office;
5. over the counter drugs and treatments;
6. certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*;

6. a Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;
7. a Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and

- adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year;
8. benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
 90. a Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year; and
 101. certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

Foot Care

1. hygienic and preventive maintenance foot care. Examples include:
 - cleaning and soaking the feet;
 - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

2. treatment of flat feet;
3. treatment of subluxation of the foot;
4. shoe inserts/orthotics (except when prescribed by a Physician for diseases of the foot or systemic disease that affect the foot such as diabetes when deemed a Covered Health Service);
5. arch supports; and

6. shoes (standard or custom), lifts and wedges.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:
 - compression stockings, ace bandages, diabetic strips, and syringes.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
 - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
 - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.
2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;
 3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;
 4. the replacement of lost or stolen Durable Medical Equipment; and
 5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services/Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;
2. food of any kind. Foods that are not covered include:
 - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
 - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
 - oral vitamins and minerals;
 - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
 - other dietary and electrolyte supplements; and
3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;
2. telephone;
3. beauty/barber service;
4. guest service;
5. supplies, equipment and similar incidentals for personal comfort. Examples include:
 - air conditioners;

- air purifiers and filters;
- batteries and battery chargers;
- dehumidifiers and humidifiers;
- ergonomically correct chairs;
- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- electric scooters;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:
 - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
 - pharmacological regimens;
 - nutritional procedures or treatments;
 - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - hair removal or replacement by any means;
 - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
 - treatment for spider veins;
 - skin abrasion procedures performed as a treatment for acne;
 - treatments for hair loss;
 - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
 - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation; and

3. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;
2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);
3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;
4. speech therapy to treat stuttering, stammering, or other articulation disorders;
5. habilitative services for maintenance/preventive treatment;
6. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;
7. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
8. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);
9. psychosurgery (lobotomy);
10. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;
11. chelation therapy, except to treat heavy metal poisoning;
12. manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;
13. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;
14. sex transformation operations and related services;

15. the following treatments for obesity:
 - non-surgical treatment, even if for morbid obesity; and
 - surgical treatment of obesity even if there is a diagnosis of morbid obesity;
16. medical and surgical treatment of hyperhidrosis (excessive sweating);
17. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations; and
18. breast reduction surgery that is determined to be a Cosmetic Procedure.

This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner or NautroPATH;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
 - prior to ordering the service; or
 - after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
3. in vitro fertilization regardless of the reason for treatment;
4. the reversal of voluntary sterilization;
5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
6. elective surgical, non-surgical or drug induced Pregnancy termination;

This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

7. services provided by a doula (labor aide); and
8. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed by a Designated Provider (this exclusion does not apply to cornea transplants); and
4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and
2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;
2. Domiciliary Care, as defined in Section 14, *Glossary*;
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing received on an inpatient basis;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;
2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

4. purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices;
5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
 - missed appointments;
 - room or facility reservations;
 - completion of claim forms; or
 - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes;
4. diagnostic tests that are:
 - delivered in other than a Physician's office or health care facility; and
 - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
5. expenses for health services and supplies:
 - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
 - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
 - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
 - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
 - that exceed Eligible Expenses or any specified limitation in this SPD;
 - for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;
6. foreign language and sign language services;
7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
8. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be

Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
 - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
 - conducted for purposes of medical research.
 - related to judicial or administrative proceedings or orders; or
 - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting mytree Support Center. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;

- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
 - the Current Procedural Terminology (CPT) codes;
 - a description of, and the charge for, each service;
 - the date the Sickness or Injury began; and
 - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for Outpatient Prescription Drug Product Benefits, your claims should be submitted to:

Optum RX
PO Box 29077
Hot Springs, AR 71903

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices

concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must

submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing.

If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral

will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

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

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after

the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits*

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	15 days
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

Post-Service Claims	
Type of Claim or Appeal	Timing
	benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Dollar Tree Management, Inc. or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Dollar Tree Management, Inc. or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Dollar Tree Management, Inc. or the Claims Administrator.

You cannot bring any legal action against Dollar Tree Management, Inc. or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Dollar Tree Management, Inc. or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Dollar Tree Management, Inc. or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;

- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.

- if this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of

the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier[s] have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare

the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan to the extent allowed under applicable state and federal law. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits that are payable in connection with services provided to other Covered Persons under the Plan. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

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

Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

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

You agree as follows:

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

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

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

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Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Dollar Tree Management, Inc. will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the date the Plan ends;
- the date you stop making the required contributions;
- the last day of the pay period for which you receive regular pay;
- the date you are no longer eligible;
- the date UnitedHealthcare receives written notice from Dollar Tree Management, Inc. to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the end of the associate's pay period in which the birthday occurs;
- the date UnitedHealthcare receives written notice from Dollar Tree Management, Inc. to end your coverage, or the date requested in the notice, if later.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and Dollar Tree Management, Inc. find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact Dollar Tree Management, Inc. has the right to demand that you pay back all Benefits Dollar Tree Management, Inc. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Dollar Tree Management, Inc. proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Dollar Tree Management, Inc.'s request, that the child continues to meet these conditions.

The proof might include medical examinations at Dollar Tree Management, Inc.'s expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Dollar Tree Management, Inc. is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Dollar Tree Management, Inc. files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a) the determination of the disability, b) the date of the qualifying event, c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)

was filed.

³From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Dollar Tree Benefits Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance'

under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Dollar Tree Management, Inc.;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Dollar Tree Management, Inc.

In order to make choices about your health care coverage and treatment, Dollar Tree Management, Inc. believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Dollar Tree Management, Inc. and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Dollar Tree Management, Inc. and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Dollar Tree Management, Inc. and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Dollar Tree Management, Inc. and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Dollar Tree Management, Inc., UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Dollar Tree Management, Inc.'s agents or employees, nor are they agents or employees of UnitedHealthcare. Dollar Tree Management, Inc. and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

Dollar Tree Management, Inc. and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Dollar Tree Management, Inc. and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Dollar Tree Management, Inc.'s employees nor are they employees of UnitedHealthcare. Dollar Tree Management, Inc. and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Dollar Tree Management, Inc. and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Dollar Tree Management, Inc. is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of the service fee to UnitedHealthcare;
- the funding of Benefits on a timely basis; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

- Are responsible for choosing your own provider.

- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.
- Must ensure you are enrolled in your selected plan when enrolling as a newly eligible Associate and each year during Annual Enrollment.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Dollar Tree Management, Inc. is that of employer and employee, Dependent or other classification as defined in this SPD.

Interpretation of Benefits

Dollar Tree Management, Inc. and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Dollar Tree Management, Inc. and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Dollar Tree Management, Inc. may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Dollar Tree Management, Inc. does so in any particular case shall not in any way be deemed to require Dollar Tree Management, Inc. to do so in other similar cases.

Information and Records

Dollar Tree Management, Inc. and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Dollar Tree Management, Inc. and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Dollar Tree Management, Inc. and UnitedHealthcare will keep this information confidential. Dollar Tree Management, Inc. and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Dollar Tree Management, Inc. and UnitedHealthcare with all information or copies of records relating to the services provided to you. Dollar Tree Management, Inc. and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Employee's enrollment form. Dollar Tree Management, Inc. and UnitedHealthcare agree that such information and records will be considered confidential.

Dollar Tree Management, Inc. and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Dollar Tree Management, Inc. is required to do by law or regulation. During and after the term of the Plan, Dollar Tree Management, Inc. and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Dollar Tree Management, Inc. recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Dollar Tree Management, Inc. and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by Dollar Tree Management, Inc. and UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to or quality of health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from Dollar Tree Management, Inc. and UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract,

including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but Dollar Tree Management, Inc. recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

Dollar Tree Management, Inc. and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Dollar Tree Management, Inc. and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been

paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Dollar Tree Management, Inc. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Company – Dollar Tree Management, Inc.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and 6, *Additional Coverage Details* and Section 15, *Outpatient Prescription Drugs*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions and Limitations* and Section 15, *Outpatient Prescription Drugs*.

Covered Person - either the Employee or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME – see Durable Medical Equipment (DME).

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy

guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to Emergency, both of the following:

- A medical screening examination (as required under section 1867 of the *Social Security Act*, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Dollar Tree Management, Inc.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services,

technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Dollar Tree Management, Inc. The KRS program provides:

- Specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are

available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator – the organization or individual designated by Dollar Tree Management, Inc. who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Dollar Tree Management, Inc. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by Dollar Tree Management, Inc., during which eligible Employees may enroll themselves and their Dependents under the Plan. Dollar Tree Management, Inc. determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a

Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Dollar Tree Management, Inc. Medical Plan.

Plan Administrator – Dollar Tree Management, Inc. or its designee.

Plan Sponsor – Dollar Tree Management, Inc.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.

- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider’s billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – an individual to whom you are legally married.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium ProgramSM Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium ProgramSM Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

You are responsible for paying the Annual Deductible stated in *Section 5*, under the *Payments and Terms* table before Benefits for Prescription Drug Products under this section are available to you.

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the *Payment Information - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

The amount you pay for any of the following under this section will not be included in calculating any Out-of-Pocket Maximum stated in your SPD:

- Coinsurance for Prescription Drug Products.
- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling the telephone number on your ID card.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and UnitedHealthcare contracted rates (Prescription Drug Charge) will not be available to you.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

Coupons: UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance or apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling the number on your ID card.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare or its designee. The reason for obtaining prior authorization from UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

The Plan may also require you to obtain prior authorization from UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in

accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from UnitedHealthcare.

If you do not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

To determine if a Prescription Drug Product requires prior authorization, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Schedule of Benefits - Outpatient Prescription Drugs***Benefit Information for Prescription Drug Products at a Network Pharmacy***

Benefit^{1,3} Description and Supply Limits	Percentage of Prescription Drug Charge Payable by You: (Per Prescription Order or Refill)
<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List (PDL) are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call the telephone number on your ID card to determine tier status.</p>	
<p>Retail</p> <p>The following supply limits apply:</p> <p>As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.²</p> <p>A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.</p> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	
<p>■ Tier-1</p>	<p>40% after you meet the Annual Deductible</p>
<p>■ Tier-2</p>	<p>40% after you meet the Annual Deductible</p>
<p>■ Tier-3</p>	<p>40% after you meet the Annual Deductible</p>

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

Benefit ^{1,3} Description and Supply Limits	Percentage of Prescription Drug Charge Payable by You: (Per Prescription Order or Refill)
<p>Prescription Drug Products on the List of Preventive Medications</p> <p>Prescription Drug Products <u>not</u> on the List of Preventive Medications</p>	<p>100%</p> <p>20% before you meet the Annual Deductible</p>
Mail Order Network Pharmacy²	
<p>The following supply limits apply: As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a Mail Order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>.</p> <p>The Plan may allow a 31-day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31-day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling the telephone number on your ID card.</p>	
<p>■ Tier-1</p>	<p>40% after you meet the Annual Deductible</p>
<p>■ Tier-2</p>	<p>40% after you meet the Annual Deductible</p>

Benefit ^{1,3} Description and Supply Limits	Percentage of Prescription Drug Charge Payable by You: (Per Prescription Order or Refill)
■ Tier-3	40% after you meet the Annual Deductible

¹Please obtain prior authorization from UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features*, under *Prior Authorization Requirements* in this section.

²The Plan pays Benefits for Specialty Prescription Drug Products and Specialty Prescription Drug Products on the List of Preventive Medications as described in this table.

³You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit www.myuhc.com or call UnitedHealthcare at the number on your ID card for the most current information.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Coinsurance.
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto www.myuhc.com.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Coinsurance. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Coinsurance for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Coinsurance that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Network Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the number on your ID card.

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Coinsurance for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the number on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, through the internet at www.myuhc.com or by calling the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see *Glossary - Outpatient Prescription Drugs*, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Please see *Glossary - Outpatient Prescription Drugs*, in this section for definitions of Specialty Prescription Drug Product and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug Product costs?

Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

How to Apply for an Exception

If an excluded drug is prescribed for a specific medical condition, you may qualify for an exception. To request an exception, submit a letter to UnitedHealthcare from your Physician stating the medical condition that requires the non-covered drug and the length of projected use. The maximum time for which a letter can justify an exception is 12 months. If your exception is approved, you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable Copay or Coinsurance amount.

If your request for an exception is denied, see *Claim Denials and Appeals* in Section 9, *Claims Procedures*, for information regarding the appeals process.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services.

Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Special Programs

Dollar Tree Management, Inc. and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on the back of your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the directed Mail Order Network Pharmacy, there will be no coverage for that drug at the retail pharmacy. If you choose to opt out of a Mail Order Network Pharmacy but do not inform UnitedHealthcare, no Benefit will be paid for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described in this section are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting www.myuhc.com or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and Dollar Tree Management, Inc. may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

1. For any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

2. Any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.
6. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
7. Prescription Drug Products dispensed outside of the United States, except in an Emergency.
8. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
9. Certain Prescription Drug Products for tobacco cessation.
10. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
11. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
12. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
13. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

14. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.
15. Prescribed, dispensed or intended for use during an Inpatient Stay.
16. Prescribed, dispensed for appetite suppression, and other weight loss products.
17. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and Dollar Tree Management, Inc. determines do not meet the definition of a Covered Health Service.
18. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
19. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
21. Unit dose packaging or repackagers of Prescription Drug Products.
22. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Dollar Tree Management, Inc. have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*.
23. Used for cosmetic purposes
24. General vitamins, except for the following which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
25. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

26. A Prescription Drug Product that contains marijuana, including medical marijuana.
27. Dental products, including but not limited to prescription fluoride topicals.
28. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
29. Diagnostic kits and products.
30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Glossary - Outpatient Prescription Drugs

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List (PDL) that are intended to reduce the likelihood of Sickness. You may obtain the List of

Preventive Medications through the Internet at www.myuhc.com or by calling the number on the back of your ID card.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling the number on your ID card.

Mail Order Network Pharmacy - a mail order pharmacy that UnitedHealthcare identifies as a preferred pharmacy within the Network.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Prescription Drug Charge - the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the number on your ID card or by logging onto www.myuhc.com.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or

administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - Standard insulin syringes with needles.
 - Blood-testing strips - glucose.
 - Urine-testing strips - glucose.
 - Ketone-testing strips and tablets.
 - Lancets and lancet devices.
 - Glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the number on your ID card.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling the number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA**What this section includes:**

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Dollar Tree Management, Inc. is the Plan Sponsor and Plan Administrator of the Dollar Tree Management, Inc. Group Health Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
Dollar Tree Management, Inc.
500 Volvo Pkwy
Chesapeake, VA 23320
(757) 321-5000

COBRA Administrator

UnitedHealthcare is the Plan's COBRA Administrator. The COBRA Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The COBRA Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the COBRA Administrator by phone at the number on your ID card or in writing at:

UnitedHealthcare Benefit Services
PO Box 221709
Louisville, KY 40252
866-747-0048

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Medical Plan
Dollar Tree Management, Inc.
500 Volvo Pkwy
Chesapeake, VA 23320
(757) 321-5000

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Dollar Tree Management, Inc. Group Health Benefit Plan
Plan Number:	501
Employer ID:	26-2018846
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective

bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and

- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

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

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200

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Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by Dollar Tree Management, Inc., the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Dollar Tree Management, Inc. are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare and Dollar Tree Management, Inc. are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

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You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة معرف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, գանգահարելք Ձեր առողջապահական ծրագրի ինքնուրոյան (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմելք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n’amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomeru ya telephone y’ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k’umugambi wawe w’ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকরে অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূন্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်မရှိစေရန်လိုအပ်သော မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အမေ့ရန်လိုအပ်သည့်အချက်ကို 0 ကိုနှိပ်ပါ။ TTY 711

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Language	Translated Taglines
19. Gujarati	તમને વનિ મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષણ માટે વનિતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ‘ana aku iā ‘oe ma ka maopopo ‘ana o kēia ‘ike ma loko o kāu ‘ōlelo pono‘ī me ka uku ‘ole ‘ana. E kama‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभाषण के लिए अनुरोध करने के लिए, अपने हेल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa imuta asusu gi n'efu n'akwughị ugwo. Maka ikpoturu onye nsughari okwu, kpoo akara ekwentị nke di n'akwukwo njirimara gi nke emere maka ahụike gi, pia 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

DOLLAR TREE MANAGEMENT, INC. BRONZE PLAN

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo báąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee níká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'i la yínikeedgo, ninaaltsoos nítł'izí 'ats'íís bee baa'ahayá bee nééhozinígíí bikáá' béésh bee hane'í t'áá jíík'eh bee hane'í biká'ígíí bich'í' hodíílnih dóó 0 bit 'adidííłchíł. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्न अघिकार तपाईंसँग छा अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिचिनुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ lɔŋ bē yi kuony nē wērēyic de thōŋ du äbac ke cin wēu tääue ke piny. Äcän bä ran yē kɔc ger thok thiëc, ke yin cɔl namba yene yup abac de ran tōŋ ye kɔc wäär thok tɔ nē ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprouch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਗਏ ਟਾਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите

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Language	Translated Taglines
	he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל, דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ifitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbuṣọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láìsanwó ibodè ti a tò sórí kádí idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

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