Benefits Resource Guide for

The Airline Technicians

And

Related Employees

And

Flight Simulator Technicians

And

Related Employees

In the Service of

United Airlines

As Represented By

The International Brotherhood of Teamsters

Dear Brothers and Sisters,

The International Brotherhood of Teamsters Benefit committee has created this "Benefits Book" to assist you in understanding your negotiated benefits and to provide you with a quick-reference, user-friendly, document. Benefits have become more complex and are an important part of your total compensation. Employee benefits, negotiated for you by your union, are part of your total compensation package. These benefits include retirement, medical, dental, long-term disability, sick leave, retiree health account, life insurance, flexible spending accounts, and survivor benefits.

Please keep in mind that this "Benefits Book" is intended to provide only a general summary of your benefits and does not address every individual situation. The Technicians Agreement and various plan documents provide in detail the terms and conditions that apply to your benefits. This Benefits Book is not an official plan document; therefore, if there is any conflict between the terms of the official plan documents and the terms of this Benefit Book, the official plan documents will govern. Additionally, this "Benefits Book" does not constitute legal, tax, investment, or other advice to any individual.

Fraternally,
International Brotherhood of Teamsters Benefit committee

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Benefit Contact Information

Health and Insurance

Prescription Drug
CVS Caremark
1-844-635-3401

United Airlines Benefits Center
Alight Solutions
1-800-651-1007

Behavioral Health
Beacon Health Options
1-800-882-6501 (US)
00 + 800-08826501 (UK, Germany & China)
0061-010-800-08826501 (Japan)

Employee Assistance Program (EAP)
Flying Together>Employee Services>
Employee Assistance Program
1-866-324-4327

Life Insurance
Securian
Questions: 1-866-293-6047
GUL: 1-866-887-1043

Group Voluntary Universal Life (GVUL)
MetLife
1-800-936-0931

Personal Accident Insurance
AIG Benefits Solutions
1-800-651-1007

Long-Term Disability (LTD)
MetLife
1-800-GET-MET-8 (1-800-438-6388)

Statutory Disability Income

1-888-825-3368 (New Jersey and New York)
1-808-522-7500 (O'ahu)
808-792-8498 (MDX Hawaii)
1-800-345-4185 (Neighbor Islands)

Your Spending Account
Alight Solutions

1-800-651-1007

Health Reimbursement Account (HRA) Or Wellness Incentive Submissions
HealthSCOPE Benefits
Company Name: United
1-800-671-3105

Savings & Retirement

401(k) Plans – Non-pilots
Fidelity
1-800-245-9034
Fidelity – United Stock Plans
Fidelity
Fidelity Executive Services Team
800-823-0217 Team 509
Fidelity Stock Plan Services
800-544-9354
Fidelity PSW Technical Help
800-735-2862
Fidelity Direct Connect Service Team
800-448-0569

Morgan Stanley – sCO Stock Plans
Morgan Stanley
866-225-7427 (Inside U.S.)
210-677-3665 (Outside U.S.)
IAM National Pension Fund

1-800-424-9608
UK Group Stakeholder Plan

Pensions Service Centre 0 800 368 6868 (within the UK)
44 1737 838 585 (outside the UK)

Continental Airlines Retirement Plan (CARP) or Continental Pilots Retirement Plan (CPRP)
Alight Solutions
1-800-651-1007
Questions about your QDRO (Qualified Domestic Relations Order)
1-800-651-1007

Pension Benefit Guarantee Corporation
Pension Benefit Guarantee Corporation
1-800-400-7242

Alliant Credit Union
Alliant Credit Union
1-800-328-1935
773-462-2000 (telephone)
773-462-2300 (TDD/TTY)

Pass Travel Program

1-877-825-3729 (inside the U.S.)
1-847-825-3729 (outside the U.S.)
e-mail: ETC@united.com

United Pass Line (UPL)

1-866-FLY-EPAS (359-3727) (inside the U.S.)
1-713-324-7277 (outside the U.S.)
Password: first time PIN is the employee's DOB (mmddyy)
Other Airline/Interline Travel

1-877-298-5233 (24hr help desk support)

General Information

Internal Revenue Service
IRS
1-800-829-1040

Social Security Administration
Social Security Administration
1-800-772-1213

Payroll Care Center

1-877-825-3729 option 6

United Employee Service Center

1-877-825-3729
Email: esc@united.com

Medicare Hotline
Medicare Hotline
1-800-633-4227

Employment and/or Wage Verification
The Work Number 1-800-367-5690

RETIREMENT
Technicians agreement Article 16

All United Technicians participate in CARP a defined contribution retirement plan.

Employees covered by the 2016 agreement (other than Guam-based employees) will participate in CARP in accordance with the terms of CARP and the Letter of Agreement between the Company and the Union dated November 4, 2010 (sCO LOA-26) and the CARP "lump sum protection" Letter of Agreement adopted under 2016 Agreement. However, employees who were governed by the sUA collective bargaining agreement immediately prior to the Effective Date of this Agreement will commence participation in CARP effective January 1, 2017.

CARP SPD

Your participation in the Plan starts the date you complete one year of eligibility service or December 28, 1988 – which ever was later.

sCO employees Before February 1, 1999 You would have completed one year of eligibility service after you were credited with 365 days following your date of hire.

After January 31 1999 You complete one year of eligibility service after you are credited with at least 1,000 hours of service in the first 12 months after you are hired or in any following plan year. A plan year is December 28th of one year to December 27th of the following year. sUA employees active on 12/5/2016 are fully vested.

A year of eligibility service was measured differently before and after February 1, 1999. The requirement for one year of participation applies to employees who were not participants as of July 1, 1989 and does not apply to anyone who worked an hour as an eligible employee between December 28, 1988 and June 30, 1989.

The Plan will first calculate your normal retirement benefit, as of age 65, then reduce this benefit for each year you begin to receive benefits before age 65. The chart below shows how your benefit would be reduced at different ages.

Actual retirement age	Percentage of age 65 benefit
50	19.18%
51	21.17%
52	23.40%
53	25.90%
54	28.69%
55	31.84%
56	35.39%
57	39.39%
58	43.93%
59	49.07%
60	54.93%
61	61.63%
62	69.29%
63	78.10%
64	88.25%

Deferred Retirement Pension. Although a Participant shall be entitled to retire on his or her Normal Retirement Date, no Participant shall be compelled to retire on that date. The Deferred Retirement Pension payable to a Participant on his or her Deferred Retirement Date shall be a pension, using the Participant's Years of Credited Service and Final Average Compensation through his or her Deferred Retirement Date.

$$\frac{\text{FAE x 1.19\% + (FAE - Covered Comp) x 0.45\% x Service}}{12}$$

Final Average Earnings (FAE): The highest 5 consecutive years out of the last 10 years

Covered Compensation: The average Social Security Wage based on 35 years prior to **retirement**

Employment Status

The Plan counts hours differently for crediting Eligibility, Vesting or Benefit Service. Take a look at the chart below for a simplified summary of how you earn service according to your employment status:

Employment Status	Credit for Eligibility and Vesting Service	Credit for Benefit Service
Active	Yes	Yes
Inactive	No	No
Furlough	No (1)	No
Leave of Absence		
• No Pay	Up to 501 hours	No
• On the Job Injury	Up to 501 hours	No
• Unpaid FMLA	Up to 501 hours	No
• Military	Depending on the circumstances 2	Depending on the circumstances (2)
• Company offered Leave	Up to 501 hours	Depending on the circumstances (3)

1 Prior to September 1, 2001, you received up to one year of vesting service when on furlough.
2 Depending on circumstances, generally you may receive up to five years vesting and benefit service when on military leave.
3 In some situations, a Company-offered leave may be eligible for benefit service. Please refer to your Company-offered leave documents you received from the Company at such time to determine if you earn benefit service during that leave and the conditions that apply.

CARP Calculations and SPD (Summary Plan Description) is available on www.flyingtogether@ual.com >employee services>Benefits, Your Benefits Resource (YBR) Under highlights>show more>Plan Documents or teamsterair.org>United banner>pay and benefits

Eligible Compensation

The chart below shows the types of compensation generally eligible for use in the final average compensation portion of the pension formula under the plan. Eligible compensation generally is not considered for periods that you are not in a eligible work-category. Beginning in 2000, for any calendar year, the maximum eligible compensation is limited to 170,000 (other limits applied prior to 2000). Thus, any compensation over 170,000 is not eligible compensation and such compensation will not be taken into account.

1 Included as Eligible Compensation	1 Not Included as Eligible Compensation
2 Regular pay	2 Bonuses or commissions
3 Before tax 401 (k) Plan contributions	3 Overtime paid prior to 1999
4 Before tax contributions for regular or Flexible benefits	4 severance pay
5 Shift differentials	5 Reimbursements, allowances or advancement of expenses (per diem)
6 Gainsharing	6 Taxable (imputed) income gained through group life insurance
7 Overtime pay after 1998	7 Non-cash or incentive compensation
	8 Profit sharing
	9 Welfare or qualified plan benefits
	10 Any income not received while in an eligible work-category

Western Conference Pension Plan

Guam based employees' pension is covered under the Western Conference of Teamsters Pension Plan.
http://www.wctpension.org/

Article 16 K b

Guam-based employees will participate in the Western Conference of Teamsters Pension Plan at the rate set forth below:

Calendar Year	2017	2018	2019	2020	2021	2022
Rate Per Hour	$4.10	$4.20	$4.30	$4.40	$4.50	$4.60

401k
Technicians Agreement Article 16 K 2

401(k). Employees covered by this agreement will be eligible for matching contributions in accordance with the following:

a. Employees who have completed less than 5 years of service – Company will match the greater of up to $300 dollar for dollar or 25% of the employee's pre-tax contributions up to 3% of eligible pay (as limited by Section 401(a)(17) of the Internal Revenue Code). That is, the first 3% of pay is eligible for the match.
For example, an employee earning $56,000 annually who contributes 3% ($1,680) will receive 25% of his $1,680 contribution ($420) as a Company matching contribution.

b. Employees who have completed 5 or more years of service, but less than 10 – Company will match the greater of up to $300 dollar for dollar or 25% of the employee's pre-tax contributions up to 4% of eligible pay (as limited by Section 401(a)(17) of the Internal Revenue Code). That is, the first 4% of pay is eligible for the match.
For example, an employee earning $80,000 annually who contributes 4% ($3,200) will receive 25% of his $3,200 contribution ($800) as a Company matching contribution.

c. Employees who have completed 10 or more years of service, but less than 15 – Company will match the greater of up to $300 dollar for dollar or 50% of the employee's pre-tax contributions up to 4% of eligible pay (as limited by Section 401(a)(17) of the Internal Revenue Code). That is, the first 4% of pay is eligible for the match.
For example, an employee earning $100,000 annually who contributes 4% ($4,000) will receive 50% of his $4,000 contribution ($2,000) as a Company matching contribution

d. Employees who have completed 15 or more years of service – Company will match the greater of up to $300 dollar for dollar or 50% of the employee's pre-tax contributions up to 6% of eligible pay (as limited by Section 401(a)(17) of the Internal Revenue Code). That is, the first 6% of pay is eligible for the match.
For example, an employee earning $100,000 annually who contributes 6% ($6,000) will receive 50% of his $6,000 contribution ($3,000) as a Company matching contribution.

For employees who were governed by the sUA collective bargaining agreement immediately prior to the Effective Date of this Agreement, the foregoing matching contributions will be effective January 1, 2017. Prior to that date, such employees will continue to receive "replacement plan contributions" under the prior agreement.

In addition, for employees who have completed 30 or more years of "Credited Service "while a participant in CARP, the Company will make additional direct employer contributions (regardless of whether the employee contributes) of 1% of eligible pay (as limited by Section 401(a)(17) of the Internal Revenue Code).

To Review the IRS changes for 2018 go to https://irs.gov

Fidelity Investments:1-800-245-9034 or online at www.401k.com

Guam employees have their 401k administered by ASC trust

671-477-2724 or online at https://www.asctrust.com

Pension Benefit Guaranty Corporation (PBGC)

To receive a PBGC pension benefit, you must be 100% vested.
The employee needs at least five years of active service before United Filed Bankruptcy to be eligible for benefits.
Participation in the plan begins the first of the month following one year of service.
Must be at least 21 years old.

PBGC Benefits are based on:

Years and months of participation. (Any month in which pay is received from UAL (after Eligibility) is credited to participation.) Your age at retirement – years and months of service when plan was terminated.

Retirement Options for PBGC:

Single Life and Joint Survivor Annuity

Option 1: 100% Straight Life Annuity

Option 2: 50% Joint / Survivor

Option 3: 50% Joint / Survivor w pop-up clause

Option 4: 75% Joint / Survivor

Option 5: 100% Joint Survivor

Time Certain Annuity

Option 6: 5 year certain

Option 7: 10 year certain

Option 8: 15 year certain

Individual PBGC Benefit Estimate:

Go online at www.pbgc.gov/mypba

Call the PBGC at 1-800-400-7242 to request an estimate three months prior to collecting benefits. New estimates contain more information than before. Employees may request one estimate per year

The United Airlines plan number is 19922400

You may not collect your PBGC benefit if you are an Active employee of UAL unless you are age 65 or older

Unreduced Retirement Benefits can also be taken if you retire at age 60 with 5 years of continuous service.

Health Coverage Tax Credit

The Health Coverage Tax Credit is a tax credit that pays 72.5 percent of qualified health insurance premiums for eligible PBGC individuals and their families. The HCTC acts as partial reimbursement for premiums paid for qualified health insurance coverage and can now be claimed for qualified coverage through 2019. HCTC toll free line:1-844-853-7210

Pan Am annuity

To determine if a participant is eligible for one or more of the annuities, they would need to contact the companies directly. See the contact information below-

• Telephone numbers are listed below for each insurance company from whom United purchased annuities. The telephone numbers will connect you with an automated telephone system that is available 24/7; the times shown below indicate the hours that telephone representatives are available on business days. You must have your policy number.

John Hancock Life	1-800-624-5155 (toll-free)
Insurance Company	8 a.m. to 3 p.m. Central time
Metropolitan Life	1-800-638-5656 (toll-free)
Insurance Company (MetLife)	7 a.m. to 10 p.m. Central time
Prudential Retirement	1-800-224-4624 (toll-free)
(Connecticut General/CIGNA)	7 a.m. to 8 p.m. Central time

Medical Plans
Technicians Agreement Article 16

Active Employee Medical Benefits, Including Prescription Drug Benefits.

1. Required Medical Plans. Effective April 1, 2017, the Company will offer the following medical plans, the first five (5) of which are collectively referred to herein as the "Core Medical Options." The plan designs and preventive services for the five (5) Core Medical Options are outlined in Appendix 16-A1 and Appendix 16-C.

a. A Core Medical PPO offered by the Company;

b. A Core Medical EPO offered by the Company;

c. A Core Medical High Deductible Health Plan with Health Savings Account ("HDHP") offered by the Company;

d. The Traditional Medical PPO;

e. NetCare Guam Health Plan Plus for employees based in Guam (if such plan becomes unavailable, the parties will meet and agree on a suitable replacement plan); and

f. The "Select Regional Medical Plans" described in Paragraph B.5, offered and maintained by the Company.

2. Optional Medical Plans. In addition to the required medical plans under Paragraph B.1 above, each eligible employee will be offered the opportunity to participate in any additional medical plan options offered by the Company. The Company will have the sole authority to establish, modify and discontinue any such additional medical plan(s) and their terms and conditions of participation (including, but not limited to, eligibility, plan design, applicable plan documents, plan rules) uniformly across all participating employee groups but may vary contribution rates by employee group. Employees based in Guam will be eligible to participate in Guam-based medical plans, subject to residency requirements of the plans.

3. Failure to Make Election During Enrollment Periods. In cases in which an employee fails to make a coverage election, the following rules will govern unless agreed to otherwise by the Union and the Company:

a. Default to current coverage if available;

b. If waived coverage, default to waive coverage;

c. If enrolled in any EPO or PPO optional plan that is being eliminated or replaced for the ensuing plan year, default to the Core Medical PPO or the Traditional PPO, whichever has the lower Required Monthly Contribution for the plan year commencing April 1, 2017 and ending December 31, 2017;

d. If enrolled in an HMO or Aetna Select option that is being eliminated or replaced for the ensuing plan year, default to a replacement HMO if available, otherwise default to the Core Medical PPO or the

Traditional PPO, whichever has the lower Required Monthly Contribution for the plan year commencing April 1, 2017 and ending December 31, 2017.

4. Required Monthly Contributions. Employees electing medical coverage under this Paragraph B will be required to make "Required Monthly Contributions" as provided in this Paragraph B.4. Required Monthly Contributions will be made by payroll deduction, except in the case of employees on unpaid leave, disability, or other status during which they are not receiving pay, in which case Required Monthly Contributions will be directly billed to, and paid by, the employee.

a. Core Option 80%/20% Limit. The Required Monthly Contributions for the Core Medical Options and Select Regional Medical Plans will not exceed 20% of the total projected cost for the Coverage Tier elected, except that this percentage will vary for the individual employee after taking into account credits and surcharges described below. For the duration of this agreement and thereafter, the Company will not increase the amount of office visit co-pays, specialty care visit co-pays, employee co-insurance, hospital visit co-pays, emergency visit co-pays, urgent care co-pays, deductible amounts, out-of-pocket maximums, and will not change the existing lifetime maximum (unlimited) for all Core Medical Options as outlined in Appendix 16-A1.

b. **Core Medical Option for Guam-based Employees.** The Required Monthly Contribution for NetCare Guam Health Plan Plus (or its successor) for Guam-based employees will not exceed twenty percent (20%) of the total projected cost for the Coverage Tier elected, except that this percentage will vary for the individual employee after taking into account credits and surcharges described below. Such Required Monthly Contribution will be determined based upon the claims experience of all employees of the Company covered under any Guam-based medical plans. For the duration of this agreement and thereafter, the Company will not increase the amount of office visit co-pays, specialty care visit co-pays, employee co-insurance, hospital visit co-pays, emergency visit co-pays, urgent care co-pays, deductible amounts, out-of-pocket maximums, and will not change the existing lifetime maximum (unlimited) for all Core Medical Options as outlined in Appendix 16-A2.

c. Optional Medical Plans. Contributions for the Optional Medical Plans under Paragraph B.2 will be set at the Company's discretion but will be included in the Aggregate Contribution Limit. Wellness credits and surcharges will apply to those plans contributions.

d. Aggregate Contribution Limit. Employee contributions for all medical plans offered by the Company under this Paragraph B (excluding the Core Medical HDHP), will not in the aggregate exceed 20% of total projected costs. Compliance with the Aggregate Contribution Limit will be determined after any required normalization of contributions to recognize the effect of any wellness credits and spousal surcharges. For the plan year commencing April 1, 2017 and ending December 31, 2017, the cost share for the plans offered to employees will be set in accordance with the provisions of this Paragraph B.4 without regard to the contractual limit on maximum year-over-year increases described in Paragraph B.4.f.

e. Credits and Surcharges. The Company has the authority to establish tobacco wellness credits and spousal surcharges. The tobacco wellness credit shall be a minimum of forty-eight dollars ($48) per month for the employee and spouse or domestic partner. The spousal surcharge shall not exceed fifty dollars ($50) per month for an employee electing coverage for a spouse or domestic partner with alternate employer-subsidized coverage available. Employees and their spouses shall not be subject to the spousal surcharge if both are employee of the Company – regardless of the spouse's labor group affiliation. If the Company determines to provide an opt-out credit or to modify tobacco wellness credit to a more general wellness credit, then the Company and the Union shall meet and agree before implementation. The Company and the Union shall determine to what extent the opt-out credit shall be taken into account in the 80%/20% Limit and the Aggregate Contribution Limit.

f. Annual Medical Cost Increases. Following the plan year commencing April 1, 2017 and ending December 31, 2017, any increase in the Required Monthly Contribution for the Core Medical Options and Select Regional Medical Plans, from one calendar year to the next, will not exceed 9.25% of the prior year's contribution. This percentage will vary for the individual employee after taking into account credits and surcharges, and changes in tier coverage.

g. Coverage Tiers. The Monthly Required Contribution will be based on a four-tier structure:

(i) Employee only or surviving spouse only or surviving Dependent children only ("employee only");

(ii) Employee and spouse ("employee and spouse");

(iii) Employee and one or more children, or surviving spouse and one or more children ("employee and child(ren)"); and

(iv) Employee and spouse and one or more children ("family").

h. Actuarial Review. The Company will provide on an annual basis the Union's actuary with the calculations and supporting data related to the determination of Required Monthly Contributions for the following plan year. Such documentation shall be provided no later than September 1 of each year.

5. Select Regional Medical Plans. Any plan offered under this Paragraph B.5 will be referred to herein as a "Select Regional Medical Plan." Unless replaced or discontinued in

accordance with this Paragraph B.5, the Company will continue to offer to eligible employees the following existing plans: all Kaiser HMOs, NetCare Guam HMO, HMO Illinois, HMO Colorado, HMSA Hawaii and Group Health Washington. In the event the Company desires to replace or discontinue offering any of the foregoing plans for the following year, it may do so, provided that:

a. in the event of replacement, the resulting disruption of employee enrollees in terms of their ability to continue utilizing the same medical providers in the proposed replacement plan is less than 20% (in which case the replacement plan will be in all respects treated as a Select Regional Medical Plan covered by Art. 16); and

b. in the event of discontinuation and not replacement:

(i) the year-over-year increase in the gross premium for such plan is more than 20% on a per capita basis; or

(ii) employee enrollment in such plan has declined to a level less than fifty percent (50%) of the enrollment on the effective date of the Agreement.

6. Survivors. An employee's Dependents enrolled in any medical option herein (as defined in Paragraph A.2.a), on the date of the employee's death will be "Survivors" entitled to continue coverage in accordance with the terms of the applicable plan document, provided that if the employee has less than 10 Years of Service, the period of continued coverage will be limited to three (3) months (exclusive of COBRA).

Active Employee Dental Benefits.

1. Required Dental Plan. Effective on April 1, 2017, the Company will offer, and each employee will be eligible to participate in, the Core Dental Option. The plan design for the Core Dental Option is outlined in Appendix 16-B.

2. Optional Dental Plans. In addition to the Core Dental Option, each employee may participate in any additional dental plan options offered by the Company. The Company will have the sole authority to establish, modify and discontinue such programs and their terms and conditions of participation (including, but not limited to, eligibility, plan design, applicable plan documents, plan rules) uniformly across all participating employee groups but may vary contribution rates by employee group. Employees based in Guam will be eligible to participate in domestic dental plans or in Guam-based dental plans subject to residency requirements of the plans.

3. Failure to Make Election During Enrollment Periods. In cases in which an employee fails to make a coverage election; the following rules will govern unless agreed to otherwise by the Union and the Company:

a.Default to current coverage if available;

b. If waived coverage, default to waive coverage; and

c. If enrolled in an optional dental plan that is being replaced or eliminated, default to Core Dental Option.

4. Required Monthly Contributions. Employees electing dental coverage will be required to make monthly contributions as provided in this Paragraph C. Required Monthly Contributions will be made by payroll deduction, except in the case of employees on unpaid leave, disability, or other status during which they are not receiving pay, in which case Required Monthly Contributions will be directly billed to, and paid by, the employee.

a. Core Option 80%/20% Limit. The Required Monthly Contributions for the Core Dental Option will not exceed 20% of the total projected cost for the Coverage Tier elected. For the plan year commencing April 1, 2017 and ending December 31, 2017, the 20% employee contribution will be based on total projected cost without regard to the contractual limit on maximum year-over-year increases described in Paragraph C.4.c.

b. Optional Dental Plans. Contributions for any optional dental plans will be set at the Company's discretion.

c. Annual Dental Cost Increases. Following the plan year commencing April 1, 2017 and ending December 31, 2017, any increase in the Required Monthly Contribution for the Core Dental Option, from one calendar year to the next, will not exceed 9.25% of the prior year's contribution.

d. Coverage Tiers. The required contribution for each month of coverage for the Core Dental Option will be based on a four-tier structure:

(i) Employee only or surviving spouse only or surviving Dependent children only ("employee only");

(ii) Employee and spouse ("employee and spouse");

(iii) Employee and one or more children, or surviving spouse and one or more children ("employee and child(ren)"); and

(iv) Employee and spouse and one or more children ("family").

5. Survivors. An employee's Dependents enrolled in any dental option on the date of the employee's death will be "Survivors" entitled to continue coverage for 3 months (exclusive of COBRA) in accordance with the terms of the applicable plan document.

Available plans are

a Aetna DHMO
b Cigna DHMO
c MetLife PPO

Active Employee Vision Benefits. Effective April 1, 2017, each employee may participate in any vision plan options offered by the Company. The Company will have the sole authority to establish such programs and their terms and conditions of participation, including, but not limited to, eligibility, plan design, applicable plan documents, plan rules, and contribution rates. Employees based in Guam will be eligible to participate in domestic vision plans or in Guam-based vision plans subject to residency requirements of the plans.

Available Plans
a Superior Vision
b VSP

F. Flexible Spending Account Plans. Each employee will be eligible to participate in the Company's flexible spending account (FSA) plans for health expenses and dependent care expenses by making an election to contribute a portion of pay. Reimbursement will be available for expenses incurred during the plan year and following the plan year through the date currently permitted by law (or later if legally permissible and administratively feasible). Forfeitures will be used to defray the administrative expenses of the program.

1. Health Care FSA. The maximum election for health expenses will be the lesser of the statutory limit (e.g., currently $2,550 for 2016) or $10,000. For any employee who participates in both the Health Care FSA and the Health Reimbursement Account (HRA), disbursements from the Health Care FSA and HRA shall be ordered in a manner that complies with Federal law (currently Health Care FSA first, followed by HRA).

2. Dependent Care FSA. The maximum election for reimbursement for dependent care expenses will be the maximum statutorily permissible election.

Introduction Flexible Spending Program
SPD Flexible spending

The Flexible Spending Program provides you with a tax-effective way to pay for health care expenses that are not covered under the Medical, Dental or Vision Programs, and to pay for dependent care expenses.
Overview of How the Flexible Spending Program Works the Flexible Spending Program offers you the opportunity to contribute a portion of your salary to the following flexible spending accounts ("FSAs"):

• a "general-purpose" health care FSA (which can be used to reimburse you for eligible health care expenses, such as medical, dental, and vision expenses);

• a "limited-purpose" health care FSA (which can only be used to reimburse you for eligible health care expenses for certain unreimbursed dental and vision services); and

• a dependent care FSA (which can be used to reimburse you for qualifying child care and other dependent care expenses).

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

You will be reimbursed for eligible health care and dependent care expenses that you have incurred upon your submission of a claim for reimbursement, along with the required documentation, as described below.
If you have any questions about the FSAs, need claim forms, or wish to access information regarding your FSA elections, or check the status of a claim for reimbursement from an FSA, you may contact the Claims Administrator at the phone number or website shown on the Contact Information Sheet.

Eligibility and Coverage Employee

Coverage If you are a regular full-time or part-time employee of the Company paid on the U.S. payroll, you are eligible to participate in the Flexible Spending Program. However, the Flexible Spending Program is not available to employees in Puerto Rico due to differences in its tax laws. Also, if you are an international flight attendant, we urge you to consult with your tax advisor before electing to enroll in the Flexible Spending Program.
Although your dependents are not eligible to enroll in the Flexible Spending Program (only employees may enroll), you may submit eligible expenses you have incurred for care provided to your eligible dependents for reimbursement from your FSAs.

FSA Contributions and Reimbursements

Determining Your Voluntary FSA Contributions After you elect to contribute to an FSA, your total annual contribution for the year will be divided into payroll deductions among the remaining payroll periods for the calendar year. If you elect an FSA benefit during the Annual Enrollment Period, this means that you will have regular payroll deductions during the following calendar year (assuming that you are in pay status for the entire year and do not terminate your FSA participation during the year).

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

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

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

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

"Grace Period" for Regular-Purpose Health Care FSA Generally, you may be reimbursed from a health care FSA only for expenses incurred while you contributed to that FSA for the Plan Year. However, if you contributed to

the general-purpose health care FSA as of the last pay period of the Plan Year, you will have an additional 2½ month "grace period" following the end of the Plan Year to incur eligible expenses to be reimbursed from the amounts remaining in your general-purpose health care FSA at the end of such Plan Year. Any unused funds remaining in your general-purpose health care FSA at the end of the grace period will be forfeited.

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

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

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

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

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

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

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

Reimbursable Health Care Expenses

Requirements of Eligible Health Care Expenses You may be reimbursed for eligible health care expenses from your health care FSA. To be eligible for reimbursement, the health care expenses must:
• be incurred by you for you, your spouse, or your dependent during the Plan Year (plus grace period) to which the funds to be used for reimbursement relate;

• qualify as expenses incurred for "medical care" under Section 213 of the Code (see IRS Publication 502 for descriptions of expenses that qualify);

• not be reimbursable under any other health plan, flexible spending account or insurance; and

• if you participate in the limited-purpose health care FSA, be incurred only for eligible dental and vision expenses, such as (1) vision exams, LASIK surgery, contact lenses, and eyeglasses or (2) dental cleanings, X-rays, fillings, crowns, and orthodontia.

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

• Your son or daughter (whether by birth, adoption, or placement for adoption) or a descendant of either (e.g., your grandchild);

• Your stepson, stepdaughter, brother, sister, stepbrother, stepsister, stepfather, stepmother, father or mother, or an ancestor of either, a niece, nephew, aunt, or uncle;

• Your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; and

• Any individual (such as a foster child) who lives in your home during the year and is dependent on you for at least half of his or her support.

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

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

Reimbursable Dependent Care Expenses

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

• the care must be provided to an "eligible dependent";

• the expenses must be for care provided primarily for the well-being and protection of the dependent (and not for educational or other purposes) or for household services which are incidental to the care of the eligible dependent;

• the care provider must meet certain requirements; and

• the care/household service must be necessary in order for you to work, and, if you are married, for your spouse to work or attend school full time (unless your spouse is disabled).

Eligible Dependent Defined

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

• your child age 12 or younger for whom you are entitled to a dependent tax exemption for federal income tax purposes; and

• a disabled spouse or legal dependent who regularly spends at least 8 hours a day in your home.

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

Eligible Expenses

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

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

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

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

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

Ineligible Expenses

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

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

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

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

• must have a taxpayer identification number (Social Security number or employer identification number);

• cannot be your child under the age of 19;

• cannot be your spouse; and

• cannot be a person that you can or do claim as a dependent for federal income tax purposes.

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

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

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

Claims for Reimbursement and Appeal

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

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

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

Technicians Agreement Article 16 Benefits

G. Health Reimbursement Account (HRA) and Retiree Health Account (RHA) Plans. There shall be established a Health Reimbursement Account Plan ("Active HRA Plan") and a separate Retiree Health Account Plan ("Retiree RHA Plan"), as of the Effective Date of this Agreement. The purpose of the Active HRA Plan and Retiree RHA Plan is to provide reimbursement of health care expenses allowed by law, including employee-paid contributions for their medical benefits.

1. Establishment of VEBA Trust. Contributions under this Section 16.G for each employee will be deposited into a voluntary employees' beneficiary association (VEBA) trust that is intended to comply with the requirements of Internal Revenue Code section 501(c) (9). Each employee will have an Active Coverage HRA Account ("Active Account") and a Retiree Coverage RHA Account ("Retiree Account").

2. Benefits. The VEBA will be used to fund benefits under the Active HRA Plan and the separate Retiree HRA Plan as follows:

a. Active HRA Plan. The Active HRA Plan will be integrated with the United Medical Plan under Section 16.B, in accordance with IRS rules and so the following rules will apply:

(i) Use of Active Account While Enrolled in Pre-retiree Medical. Each employee who is enrolled in active Medical coverage under Section 16.B will be a participant in the Active HRA Plan. As a

participant in the Active HRA Plan, the employee may use the funds in his or her Active Account to pay for qualified medical expenses under Section 213(d) of the Internal Revenue Code, including the Required Monthly Contribution required for active Medical coverage.

(ii) Suspension of Active Account While Not Enrolled in Active Medical. An employee may not utilize the funds in his or her Active Account for dates of medical service in which the employee was not enrolled in active Medical coverage under Section 16.B. If the employee again enrolls in active Medical coverage under Section 16.B, the employee can utilize any funds in his or her Active Account for dates of medical service during which the employee is enrolled. In addition, if the employee leaves the Company, funds again become available as described in Section 16.G.2.b.

(iii) Transfer of Active Account to Retiree Account. Once an employee leaves the Company due to retirement or for any other reason, the employee ceases participation in the Active HRA Plan and instead becomes a participant in the Retiree RHA Plan. Any remaining funds in the employee's Active Account will be transferred to the employee's Retiree Account to fund benefits under the Retiree RHA Plan. The timing and manner of transfer is subject to legal and administrative requirements as determined by the Company.

b. Retiree RHA Plan. The Retiree RHA Plan will be a retiree-only plan available to employees who retire or leave the Company for any other reason on and after the Effective Date of this Agreement. When an employee leaves the Company for any reason, the employee will become an active participant in the Retiree RHA Plan and may use the funds in their Retiree Account to pay for qualified medical expenses under Section 213(d) of the Internal Revenue Code. Funds in an employee's Retiree Account cannot be transferred to an Active Account (e.g., in the event of rehire).

c. Additional Rules:

(i) Dependents. Benefits will be payable with respect to the employee and the employee's eligible spouse and dependents as determined in accordance with Section 152 of the Internal Revenue Code (that is, they must qualify as tax dependents under IRS rules).

(ii) Surviving Dependents. If the employee dies, the surviving eligible spouse and/or dependents will remain eligible for the benefits described above paid from the employee's Active Account or Retiree Account, as applicable.

(iii) Reallocation. Once the Employee and all of the employee's surviving eligible spouse and dependents have died or ceased to be eligible, the remaining portion of the employee's Active Account or Retiree Account, as applicable, will be forfeited and re-allocated per capita among the accounts of the remaining participants in the VEBA covered by this agreement.

(iv) Direct Payment of Premiums. The Active HRA Plan may provide, if administratively feasible, for direct payment of employee contributions for pre-retiree medical coverage under this Article 16.

(v) Employees on Furlough or Long-Term Disability. For an employee on furlough or who is receiving long-term disability benefits, once five (5) years from the employee's last day worked has passed, the balance of the employee's Active Account will be transferred to the employee's Retiree Account within sixty (60) days; provided, however, that the employee may make a one-time election prior to that date to transfer the balance of the employee's Active Account to the Employee's Retiree Account (i.e., cease

participation in the Active HRA Plan and commence participation in the Retiree RHA Plan). Funds in an employee's Retiree Account cannot be transferred to an Active Account (e.g., in the event of rehire).

d. Employer Contributions. Effective April 1, 2017, $1.20 per hour will be contributed by the Company on all compensable hours to the employee's Active Account or Retiree Account, as applicable, as a mandatory contribution (up to 2,080 hours per calendar year, pro rated per calendar year based on weeks in active status).

(i) Contributions to Active Account. Any contributions made while an employee is enrolled in a Company sponsored active medical plan described in Section 16.B will be made to the employee's Active Account in the Active HRA Plan. Funds in an employee's Active Account can be used as described in Section G.2.a.

(ii) Contributions to Retiree Account. Any contributions made while an employee is not enrolled in a Company sponsored active medical plan described in Section 16.B will be made to the employee's Retiree Account in the Retiree HRA Plan. Funds in an employee's Retiree Account can be used as described in Section G.2.b.

e. Effect of Contributions on Other Benefits. Any contributions under this Section 16.G will be excluded from the calculation of any other benefits that are based upon an employee's pay (e.g., profit sharing, disability insurance, overtime, pension benefits, etc.).

f. Timing of Contributions. Effective April 1, 2017, contributions will be made bi-weekly by the Company, or weekly for locations where employees are paid on a weekly basis.

g. Employee Contributions. An employee is not permitted to make contributions to the Active HRA Plan or the Retiree RHA Plan.

h. Administration and Investments. The Company will be responsible for all costs and expenses related to the administration of the Active HRA Plan and the Retiree RHA Plan and the investment of funds held in the VEBA and shall be the fiduciary with respect to such matters (or shall appoint one or more fiduciaries). Funds held in the VEBA shall be invested conservatively with the goal of preserving principal.

i. Program Conditioned Upon IRS Ruling. Following implementation of the program described above, the Company shall file with the Internal Revenue Service a request for qualification of the VEBA and a private letter ruling on the design of the program. If the IRS determines that any portion of the program is impermissible under Federal law, the Company and the Union shall meet to discuss modifications to the program in order to bring the program into compliance with Federal law. If modifications cannot be reasonably made, then the parties shall agree upon a reasonable replacement program of comparable value.

Retiree Bridge Medical
Technicians Agreement Article 16

Retiree Bridge Medical Plan. Each employee covered by this Agreement shall be eligible to participate in a Retiree Bridge Medical plan, which shall allow such retirees to elect to continue their existing Medical benefits coverage under the following conditions:

a. Participants must be between the ages of sixty (60) and Medicare eligibility age, be retired, and have at least ten (10) years of Company service at the time of retirement.

b. At the time of retirement the balance in an employee's sick bank will permit the employee to maintain Medical benefits coverage as a retiree by using eleven (11) hours of sick leave for each month of continued participation. Payment of the eleven (11) hours of sick leave shall be accepted as the retiree's complete payment obligation to the Company for the Company to pay the Retiree Contribution on behalf of such retiree and any eligible dependents for each such month of Medical benefits coverage.

c. If a retiree has insufficient sick leave remaining in his or her bank to purchase continued participation in Medical benefit coverage for any period of time for which he is eligible and desires such coverage, he may obtain coverage at a non-contributory rate.

d. Coverage for the retiree terminates when the retiree becomes eligible for Medicare. Spouse/dependent coverage will be available on the same basis, but must terminate when the spouse/dependent becomes eligible for Medicare or the retiree dies (except that upon the retiree's death, the spouse/dependent may elect to use any remaining sick leave in the manner described above, and then will be eligible for COBRA coverage).

e. Once an employee becomes an eligible retiree and elects to participate in the Retiree Bridge Medical plan, the termination of the Retiree Bridge Medical plan will not affect the retiree's continued eligibility.

f. For any employee who retires after the end of the ten (10) year period commencing on the Effective Date of this Agreement, coverage under this provision will be available solely at the non-contributory rate (i.e., retiree pays 100% of the retiree medical premium with no use of sick bank to pay premiums).

Retiree Bridge Medical
Retiree Bridge SPD

If you are eligible for Retiree Bridge Medical, you may be able to use your sick bank hours to pay for each month of coverage. The number of sick bank hours depends upon your retiree group, which is either stated in the collective bargaining agreement or was communicated to you at the time of your retirement. You can also find out the number of hours by calling the UABC. If you exhaust your sick bank (or had no hours at the time of retirement), you are only eligible for Regular Retiree Medical (*see below*). For example, assume you retire at age 60 with 700 sick bank hours and you are in an retiree group that is charged 11 sick bank hours per month to cover yourself and any dependents. In that case, your 700 hours of sick bank will be sufficient to purchase the five years of coverage necessary to bridge you to Medicare (which is generally when you reach age 65). If you have fewer sick bank yours and retire at age 60, you might not have sufficient hours to bridge to Medicare. However, once your sick bank hours are exhausted, you would still have access to coverage through Regular Retiree Medical as described below.

You may elect coverage for yourself and any eligible dependents within 45 days following your retirement. You will be covered under the Retiree Bridge Medical or Regular Retiree Medical component on the first day of the month following your retirement (unless your retirement is as of the first day of the month, in which case your coverage will begin on the date your retirement begins). You can find the current cost of coverage for each medical plan option and additional information needed to complete enrollment:

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

If you are not enrolled for coverage as an active employee on the date your retirement begins, you cannot elect coverage under either component of the Program. In addition, if your existing eligible dependents are not enrolled under your active coverage on the date your retirement begins, you cannot elect coverage for them under either component of the Program. You may enroll a new child within 30 days after his or her birth, adoption, or

placement for adoption, but other new dependents cannot be added (i.e., new spouses and domestic partners cannot be enrolled under the Program). If you timely enroll a new child, coverage will take effect on the date of birth, adoption, or placement for adoption, as applicable. **If you do not request the change within the applicable 30-day period for a new dependent, you will permanently lose your enrollment rights for that dependent.** If you would be eligible for Retiree Bridge Medical coverage except that you are already eligible for Medicare, you still may elect coverage for your eligible dependents. Coverage for your eligible dependent(s) will begin the first day of the month following your retirement (unless your retirement is as of the first day of the month, in which case your coverage will begin on the date your retirement begins). During each subsequent Annual Enrollment Period, which is usually during the fourth calendar quarter of the year, you will be provided with an opportunity to change your coverage, and that of your dependents, effective as of the following January 1.

Dependent
Your dependents include: your spouse or qualified domestic partner and your eligible children. Supporting documentation must be provided when requested.

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

Eligible Child
Your eligible dependents include the following individuals: (1) your eligible child younger than age 26 by birth or legal adoption, including a child legally placed in your custody for your adoption and (2) an eligible child who is your unmarried child, who is age 26 or older, who is primarily dependent (over 50%) on you for support and maintenance and who has been continuously incapable of self-sustaining employment because of a mental or physical disability since before age 26 (even if you did not have coverage under the Plan at that time). Self-sustaining employment means that your child is able to work on a full-time basis (typically 40 hours per week) and earns at least the federal minimum hourly wage. Such child will cease, forever, to be an eligible child on the first date such child is no longer primarily dependent on you for support or is able to earn a living. You must provide the UABC with satisfactory proof of your child's disability within 60 days before the date the child attains age 26 and at any later time requested. If proof is requested by the UABC and is not furnished within 60 days of such request, such child will cease to be considered an eligible child effective as of such 60th day. The term "child" includes any child who is primarily dependent (over 50%) upon you for support and maintenance, is living with you in a normal parent-child relationship and is: (1) your stepchild, (2) a child of your qualified domestic partner, or (3) a child for whom you are a court appointed permanent legal guardian. Unless otherwise specified in an applicable insurance policy, a child who is in the military service is not eligible for coverage.

Qualified Domestic Partner
The term "qualified domestic partner" means your same-gender domestic partner for whom you have filed the required proof of domestic partnership with the Company and with whom your domestic partnership has not terminated. Company-approved forms are available by calling the UABC. If your qualified domestic partner is covered as a dependent (and is not an employee of the Company), then the value of the coverage (based on the Company's cost of medical coverage for the "1 Adult "coverage tier) must be reported as additional income to you (and may be subject to withholding taxes).*Please note, some HMOs may have their own rules regarding coverage for domestic partners (including not providing such coverage at all). The HMO is the final authority in determining eligibility for domestic*
partners under an HMO option.
NOTE: Domestic Partners are eligible for coverage under the Plan solely to the extent permitted under Company policy and/or any applicable collective bargaining agreements.

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

Court Ordered Enrollment
An exception to the dependent enrollment rules described above is that your eligible child may be enrolled outside the normal enrollment window if the Plan Administrator receives a notice or an order that qualifies as a "qualified medical child support order" requiring you to pay for dependent coverage that is available through the Program. You may change your medical coverage elections at any time if required to do so by a QMCSO. This change will be effective on the first day of the month following the QMCSO's effective date or the date of notification, whichever is later. For the Plan's QMCSO procedures, please contact the UABC.

Deleting Dependents
If one of your dependents ceases to be eligible for coverage, you must notify the UABC within 60 days after the date your dependent becomes ineligible. This includes situations where:

• Your child loses eligibility;
• You and your spouse divorce; or
• Your qualified domestic partnership is terminated.
If the Company determines that your dependent is no longer eligible for coverage, he or she will immediately be removed from coverage as of the ineligibility date. You may also be held liable for reimbursing the Plan for any expenses paid by the Plan on your dependent's behalf after he or she was no longer eligible for coverage.

When Coverage Ends

For You
Your coverage ends upon the earliest of the following:
• The last day of the calendar month in which you become eligible for Medicare or, if your Medicare eligibility date is on the first day of the month, the last day of the calendar month preceding the month of such eligibility (unless another coverage end date is specified in the collective bargaining agreement applicable to your coverage).
• The date of your death
• The first day of the month following your election to discontinue coverage
• The last day of the calendar month preceding the month for which required contributions (premiums) have not been made (for Regular Retiree Medical coverage only)
• In accordance with a notice of termination of coverage for cause (e.g., for fraudulent claims)
• The date the Program is terminated with respect to a class of retirees of which you are a member In addition, if you are receiving Retiree Bridge Medical coverage and exhaust all of your sick bank or you are a retiree (*other than a former sub-Continental Technical Operations employee*) and you have received retiree coverage for 60 months, your coverage ends under the Retiree Bridge Medical component of the Program. If you have remaining time before your Medicare eligibility, you will automatically be enrolled in the Regular Retiree Medical coverage as of the first day of the month following loss of coverage under the Retiree Bridge Medical component for either of these two reasons.

For Your Dependents
Similar to the rules above, coverage for eligible dependents comes to an end upon the earliest of the following
• The last day of the calendar month in which he or she is no longer an eligible dependent

• In the case of a covered spouse or qualified domestic partner, the last day of the calendar month in which he or she becomes eligible for Medicare or, if his or her Medicare eligibility date is on the first day of the month, the last day of the calendar month preceding the month of such eligibility (unless another coverage end date is specified in the collective bargaining agreement applicable to his or her coverage)
• The date of your death
• The date of the eligible dependent's death
• The first day of the month following the election by you or the eligible dependent to discontinue coverage
• The last day of the calendar month preceding the month for which required contributions (premiums) have not been made (for Regular Retiree Medical coverage only)
• In accordance with a notice of termination of coverage for cause (e.g., for fraudulent claims)
• The date the Program is terminated with respect to a class of retirees of which you are a member In addition, if you are receiving Retiree Bridge Medical coverage and exhaust all of your sick bank hours or you are a retiree (*other than a former sub-Continental Technical Operations employee*) and you and/or your eligible dependents have received retiree coverage for 60 months, your eligible dependents' coverage ends under the Retiree Bridge Medical component of the Program. They will automatically be enrolled in the Regular Retiree Medical coverage as of the first day of the month following loss of coverage under the Retiree Bridge Medical component for either of these two reasons.

SPD Addendum Technicians and related

Benefits After Retirement Program
Retiree Bridge Medical
Eligibility Requirements

See the eligibility requirements in the collective bargaining agreement applicable to your employee group. For your convenience, Article 16.H.3 of the Mechanics' Agreement is reproduced below:

"3. Retiree Bridge Medical Plan. Each employee covered by this Agreement shall be eligible to participate in a Retiree Bridge Medical plan, which shall allow such retirees to elect to continue their existing Medical benefits coverage under the following conditions:

a. Participants must be between the ages of sixty (60) and Medicare eligibility age, be retired, and have at least ten (10) years of Company service at the time of retirement.

b. At the time of retirement the balance in an employee's sick bank will permit the employee to maintain Medical benefits coverage as a retiree by using eleven (11) hours of sick leave for each month of continued participation. Payment of the eleven (11) hours of sick leave shall be accepted as the retiree's complete payment obligation to the Company for the Company to pay the Retiree Contribution on behalf of such retiree and any eligible dependents for each such month of Medical benefits coverage.

c. If a retiree has insufficient sick leave remaining in his or her bank to purchase continued participation in Medical benefit coverage for any period of time for which he is eligible and desires such coverage, he may obtain coverage at a non-contributory rate.

d. Coverage for the retiree terminates when the retiree becomes eligible for Medicare. Spouse/dependent coverage will be available on the same basis but must terminate when the spouse/dependent becomes eligible for Medicare or the retiree dies (except that upon the retiree's death, the spouse/dependent may elect to use any remaining sick leave in the manner described above, and then will be eligible for COBRA coverage).

e. Once an employee becomes an eligible retiree and elects to participate in the Retiree Bridge Medical plan, the termination of the Retiree Bridge Medical plan will not affect the retiree's continued eligibility.

f. For any employee who retires after the end of the ten (10) year period commencing on the Effective Date of this Agreement, coverage under this provision will be available solely at the non-contributory rate (i.e., retiree pays 100% of the retiree medical premium with no use of sick bank to pay premiums)."

Type of Retiree Medical Coverage
Retiree bridge medical providing for participation in the domestic medical plans available to active employees, subject to the rules specified in the collective bargaining agreement applicable to your employee group

A. Sick/Occupational Injury
Technician Agreement Article 11

Sick/occupational injury time is provided to allow the necessary time off to recuperate from illness or injury. An employee on sick or occupational injury leave may not accept employment or receive pay for services from any other organization without prior written approval from the employee's supervisor/manager and Human Resources.

B. Definitions

1.Sick Pay - is pay to an eligible employee who cannot perform his regular duties because of sickness (physical or psychological) or non-occupational injury, including maternity. Sick pay may also be utilized when an employee's presence would jeopardize the health of others because of exposure to a contagious disease. Sick pay does not cover time for routine physical examinations or dental check-ups. Examinations, tests and treatment for specific medical conditions are not considered to be "routine physical examinations." Pay during a period of sick absence will be based on the employee's base rate and scheduled hours.

2.Occupational Injury Pay - is pay to an eligible employee who is unable to work because of an injury on the job at United The injury must be one that is covered by the applicable state Workers' Compensation law, and must be verified in writing by the treating physician. Pay during a period of occupational injury absence will be based on the employee's base rate of pay and scheduled hours. Pay received from the Company for an occupational injury will be at a rate equal to the employee's base rate of pay times his regularly scheduled hours, reduced by the amount of Worker's Compensation Temporary Disability Pay received by the employee from the Company's insurance carrier, or the state.

3.Worker's Compensation Temporary Disability Pay - is pay to an eligible employee unable to work because of an injury on the job at United

a. The injury must be one that is covered by the applicable state Worker's Compensation law, and must be verified in writing by the treating physician. Pay during the period of occupational injury absence is based upon a seven-day work week, whether or not an employee is scheduled to work.

b. Payment for occupational injury by the Company's insurance carrier, or the state, is generally set at a percentage of the employee's average weekly wage. However, this rate and the maximum weekly payment may vary from state to state. Occupational injury pay (described above) is used to make up the difference between Worker's Compensation Temporary Disability Pay and the employee's base rate of pay for his scheduled straight time hours.

4. State Mandated Benefits - are disability income benefits required by law in certain states. State mandated benefits may include or require payments from an outside source.

a. In no event may an employee be entitled to State Mandated Benefits and Sick Pay or Occupational Injury Pay in excess of the employee's normal base rate times his scheduled straight time hours.

b. Adjustments to reimburse any excess compensation may be made by payroll deduction after the employee has received notification of the intent to do so. Repayment schedules will be discussed with the employee prior to implementation and will not exceed fifty dollars ($50) per pay check except by express agreement with the employee. Such adjustments will not result in restoring hours to the employee's accrued occupational injury pay credits but will result in hours being restored to an employee's sick leave bank if his sick leave bank was overdrawn. See paragraph F below.

5. Base Rate, as used in this Article, is an employee's basic hourly rate (Appendix A) plus all premiums he normally receives.

C. Sick and Occupational Injury Accrual

1. Effective upon the date of signing of this Agreement, full time employees who, as of that date, are on the United Airlines System Seniority List shall accrue eight (8) hours of Sick Pay credits and eight (8) hours of Occupational Injury Pay credits, for each month that they are in a paid status up to a maximum of one thousand six hundred (1,600) hours for Sick Pay and a maximum of seven hundred (700) hours for Occupational Injury Pay. An employee whose single instance of illness or injury causes him to use more than two hundred and forty (240) hours of paid sick leave (i.e., a catastrophic long-term illness or injury) will upon his return to work replenish his sick bank at a rate of twelve (12) hours per month until the bank is restored to the amount he had the day before the illness or injury began. Thereafter he will resume accruing at the regular amount of eight (8) hours per month

Employees whose Occupational Injury (OI) Bank is already at or above seven hundred (700) hours will maintain their existing banks but will not accrue additional OI hours until such time as his bank falls below seven hundred (700) hours at which point he shall start to accrue again up to a maximum of seven hundred (700) hours.

D. **Commencement and Payment of Non-Occupational Sick Time**

Non-Occupational Sick time is paid based on the number of hours in the employee's regular work schedule. Pay will be at the employee's base rate until his/her sick bank has been exhausted.

E**.** **Commencement of Occupational Injury Pay**

Occupational Injury Pay is based on the number of hours in the employee's regular work schedule.

F. **Combining Non-Occupational Sick Time ~~Pay~~ and Occupational Injury Pay**

Employees may not use Occupational Injury Pay to extend paid sick time. However, if an employee exhausts Occupational Injury Pay, available Non-Occupational_Sick Time may be used to extend Occupational Injury Pay. Only those hours needed to make the employee whole will be deducted from his sick leave bank if used to extend an occupational injury. "Those hours needed to make the employee whole" as used in this Article shall mean a payment in the amount that would ensure that an employee is paid an amount equal to his normal full wage compensation (his hourly base rate of pay times his regular scheduled work hours).

G. **Exhaustion of Non-Occupational Sick Time /Occupational Injury Pay**

When an employee exhausts all paid non-occupational sick time /occupational injury pay, the employee will be placed on an Extended Illness Status, as defined in Article 10(E)(2). An employee will not accrue Non-Occupational Sick Time or Occupational Injury Pay while on Extended Illness Leave.

H. **Physical Examinations**

Subject to applicable state law:

1. United may require an employee to submit to a physical examination by a Company approved physician. This may be requested to verify the employee's illness, disability, occupational injury, fitness for duty or release to duty. The cost of this examination will be borne at Company expense. In addition, an employee will be pay protected for time lost because of said examination if he is at work.

2. If the employee does not agree with the findings of the Company doctor, he may be examined by a doctor of his own choosing. Should a dispute arise between the findings of the two doctors concerning the employee's physical ability to return to work, after either an occupational injury or use of non-occupational sick time, a third doctor, selected by mutual agreement by the first two doctors will make a third examination, and the decision of the third doctor will be determinative. The expense of the third doctor shall be borne by the Company.

I. Travel While on Sick or Occupational Injury Status

Employees on sick or occupational injury status may not use their own or another employee's pass privileges or reduced rate travel for personal travel unless written permission is secured in advance of the travel from the appropriate supervisor or Human Resources Manager, which permission will not be unreasonably withheld. Eligible family members (and buddies if accompanied by the employee's spouse or other eligible family pass rider, when accompaniment is required) are permitted to travel while the employee is in a paid status. To allow time for family members to return from trips in progress or be notified to make alternate travel arrangements, eligible family members may continue to travel for 30 days from the date an employee's status changes to "unpaid" (i.e., an employee has exhausted Non-Occupational Sick Time/Occupational Injury Pay).

J. Occupational Injury Pay

1. Eligibility

To be eligible to receive Occupational Injury Pay, an employee's disability must be covered by the state Worker's Compensation laws applicable to the employee's base, station or work site. The employee must also provide a medical doctor's written verification of disability by occupational injury.

2. Limited Duty

Limited Duty assignments will be available for employees who are unable to return to full duty after an on-the-job injury but are capable of performing work with some physical restrictions. An employee who has applied, and been qualified, for Long Term Disability benefits provided under Company-sponsored plan(s) will not be forced to perform limited duty assignments.

3. Payments

Worker's Compensation Temporary Disability payments will be made directly to the employee by the Worker's Compensation carrier (or the state) in the amount equal to the statutory requirements. Payments will be made to the employee, by the Company, in the amount calculated to be the difference between the employee's regular base pay and the statutory payment amount, until such time as the employee's Occupational Injury Pay and (if elected) Non-Occupational Sick Time are exhausted. Hours will be deducted from the employee's Non-Occupational sick bank, if elected, on an hour for hour basis rounded off to the nearest hour. Only those hours needed to make the employee whole will be deducted from his bank. After the employee has returned to work and occupational injury payments have ceased (from both the Company and the third party), reconciliation will be performed to determine that the employee was appropriately paid during this period. Final adjustments will then be made. If it is established that the employee was overpaid, arrangements will be made with the employee for prompt recovery. A pay inquiry will be initiated if, after all adjustments have been made, the employee believes that he was paid improperly.

4. Denial/Investigation of Worker's Compensation Claims

Occupational Injury payments will not be made if there is an unresolved controversy as to whether the injury is compensable or if the claim is denied. An employee who is denied Occupational Injury Pay may use other benefits such as sick pay or vacation pay. If an injury is later deemed eligible for Worker's Compensation Temporary Disability Pay, payments will be retroactive, and the necessary adjustments/changes will be made.

K. **Limited Duty**

1. Eligibility

a. Limited Duty assignments are available only for employees who sustain occupational injuries and are temporarily unable to perform their full duties.

b. The employee must provide a treating and/or consulting physician's statement stating that the employee's physical limitations are not expected to restrict him from regular work duties for more than ninety (90) days.

c. The Company will make work available in a position covered by this Agreement at the employee's Station/Point.

d. The employee must be capable of performing the work that is available within the doctor's written restrictions.

2. Limited Duty Requirements

a. Limited Duty assignments may last as long as ninety (90) days. In addition, thirty (30) day extensions may be allowed with the treating and/or consulting doctor's approval and mutual agreement between the Company and the Union.

b. An employee whose restrictions are not removed and is not granted an extension will be returned to either Non-Occupational Sick Time, Occupational Injury Pay or EIS status.

c. Employee participation in Limited Duty is mandatory, if the treating and/or consulting physician releases the employee for Limited Duty.

d. Once the treating and/or consulting physician issues a full release, an employee on Limited Duty must return to his normal job duties immediately.

e. An employee on Limited Duty will only be assigned work at his Station/Point (including corporate offices located at or near the Station/ Point). Employees will not be given Limited Duty assignments which require supervision of employees covered by this Agreement.

f. An employee assigned Limited Duty will be paid at his regular base rate as used in this Article, even if the Company would otherwise pay a 1ower rate for the assigned work.

3. Effects on Employee Benefits/Privileges

a. Seniority

An employee on a Limited Duty assignment will continue to retain and accrue Seniority for all purposes.

b. Overtime

Employees on limited duty assignments are eligible for overtime only if the available overtime would not violate their medical restrictions.

c. Trade Days

An employee on Limited Duty assignment is not permitted to use trade privileges.

d. Occupational Injury Pay

Employees on Limited Duty assignments are paid their regular rate. No deductions are made from their Sick or Occupational Injury Pay for hours actually worked while on the assignment.

e. Attendance

Employees will be held accountable for attendance and tardiness while on Limited Duty assignments, except in circumstances where the employee's attending physician requires the employee to be absent or tardy for treatment or therapy.

f. Travel Privileges

Pass and reduced-rate travel is available to employees and their eligible dependents while employees are on Limited Duty assignments.

g. Vacation, Sick Pay and Occupational Injury Pay Accruals

During a Limited Duty assignment, accruals will be credited in the same manner as if the employee were performing his regular assignment.

h. Transfers

Transfers are not available to employees on Limited Duty.

L. An employee who has incurred a permanent disability will receive consideration for return to duty in accordance with the Company's policies regarding reasonable accommodation for handicapped individuals. That is, an employee who has suffered an occupational injury and has medical restrictions defined as permanent and stationary, but remains unable to perform his normal duties, will be given consideration for other work that does not exceed the restrictions, to the extent it is available, and he is qualified to perform such work. Once a limitation defined as permanent and stationary is recognized by the Worker's Compensation Board, that determination cannot be changed unless the Company elects in its discretion to accept the diagnosis of another physician. (Moved from Above)

M. Non-Critical Illness in the Family

If an employee's spouse or dependent child is injured, or becomes ill, or is hospitalized so that the employee is unable to report for work, the employee will be entitled to use up to six (6) working days of personal sick leave. Beginning with either the seventh (7^{th}) working day or the third such instance, whichever comes first in a rolling twelve (12) month period, absences of this nature are treated the same as employee sick time, and will count for attendance/disciplinary purposes.

CLAIMS HANDLING: WORKERS COMPANSATION CARRIER IS SEDGWICK

Submit Medical Notes, Medical Bills/Invoices

Mail	E-Bill	Fax
Sedgwick PO Box 14155 Lexington, KY 40512-4155	United6925Images@Sedgwick.com	1-844-810-4365

Reporting your injury:

Report your injury to your supvr/mgr as soon as possible and they will record the injury in OIS.	Go to a United onsite clinic in ORD/EWR/IAH and the clinic will record the injury in OIS

SEDGWICK BRANCH LOCATIONS

Sedgwick Branch	**States Covered**	**Branch Phone Number**
Alaska, Anchorage	AK	907-339-4600
California, Brea	So CAL	800-221-5473
California, Pleasanton	No CAL	877-809-9478
Colorado, Denver	AZ, CO, UT, WY	800-507-9656
Florida, Lake Mary	AL, AR, FL, GA, KY, MS, NC, SC, TN	800-548-1373
Hawaii, Honolulu	HI	808-523-3200
Idaho, Meridian	ID	866-253-1074

Illinois, Aurora	IL,IN,IA,KS,MI,MN,MO,NE,SD,WI	800-358-2072
Maine, Portland	MA, ME, NH, RI, VT	800-526-3721
Maryland, Hunt Valley	CT, DC, DE, MD, VA, WV	877-494-8010
Montana, Helena	MT	866-458-4737
Nevada, Las Vegas	NV	702-568-3740
New Jersey, Marlton	NJ, PA	800-630-0746
New Mexico, Albuquerque	NM	800-255-4349
New York, Syracuse	NY	800-826-4338
Ohio, Hilliard	OH	800-267-4001
Oregon, Portland	OR, WA	800-906-3147
Texas, San Antonio	LA, OK, TX	800-800-3795

Long Term Disability Insurance
Technicians Agreement Article 16

Long Term Disability Insurance (50% Company Paid), employee may elect:
(i) 50% annual base pay, $10,000/mo. maximum, 180 day waiting period;
(ii) 60% annual base pay, $10,000/mo. maximum, 180 day waiting period; or
(iii) 60% annual base pay, $10,000/mo. maximum, 120 day waiting period.

Coverage Effective Date

You will be eligible to enroll in the LTD Program after six months of continuous service as an employee effective on the first day of your seventh month of employment. If you are not actively at work on this date, then your coverage (including any increase in your coverage) will take effect when you return to active full-time work for one day.
If you are a newly eligible employee, unless you make a different coverage election, you will be automatically enrolled in the 60%/180-Calendar day elimination period coverage option described below.
If you timely enroll when you first become eligible, your coverage will be effective on that date. If you request to enroll more than 45 calendar days after the day you first become eligible you must provide evidence of good health. If you enroll during a subsequent Annual Enrollment Period, your coverage will become effective the later of January 1 following the Annual Enrollment Period during which you elected to participate or the date your evidence of good health is approved.

Declining Coverage

If you do not wish to be enrolled in the LTD coverage, you can cancel your LTD enrollment by going to the Plan Website to cancel coverage or you can call the United Airlines Benefits Center (UABC) to cancel your LTD benefit coverage. If you cancel your LTD coverage and you wish to participate at a later date, you will be required to submit evidence of your good health.

When LTD Coverage ends

Your LTD benefit coverage will end when the first of the following events occurs:
• The date the group policy ends; or
• The date insurance ends for your employee group; or
• The end of the period for which the last premium has been paid for you; or
• The date you cease to be in an eligible employee group. You will cease to be in an eligible employee group on the last day of the calendar month in which you cease active work in an eligible class, if you are not disabled don that date; or
• The last day of the calendar month in which your employment ends; or
• The date you retire in accordance with the last day of the calendar month in which your employment ends.

Reinstatement

If your LTD benefit coverage ends because you stop active work you may reinstate the coverage you previously had without having to complete a new eligibility waiting period (as described above) if you return to active work within three months of the date your coverage ended.

Contributions .

To participate in the LTD Program, you must make contributions to the Plan through payroll deductions. These contributions are made on an after-tax basis. You may contact the United Airlines Benefits Center (UABC) or via the web at flyingtogether.ual.com to obtain the cost of the coverage. The contribution rate is subject to change

Elimination Period Before Benefits Begin

Your elimination period begins on the day you become Totally Disabled. It is a period of time during which no benefits are payable. You must be under the continuous care of a doctor during your elimination period. The doctor must be legally qualified, practicing within the scope of his or her medical license, not related to you, and must prescribe treatment and care consistent with established medical guidelines. If the disability is consistent with a mental health or psychiatric condition, the doctor must specialize in psychiatry. You may temporarily recover from your Total Disability during your elimination period. “Temporary recovery” means you cease to be Totally Disabled. During a period of temporary recovery, you will not qualify for any change in coverage caused by a change in the rate of earnings used to determine your Predisability Earnings. If you then become Totally Disabled again due to the same or related condition within six months of continuous active work, you may not have to begin a new elimination period. If you return to work for 45 calendar days or less during your elimination period, those days will not count towards your elimination period but will extend your elimination period by the number of days you return to work. However, if you return to work for more than 45 calendar days before satisfying your elimination period, you will have to begin a new elimination period.

Coverage Options

You may select one of three coverage options that vary by benefit amount and the length of elimination period.

Option/Benefit Amount	Elimination Period (Before Payments Begin)
60% of Predisability Earnings	120 Calendar days
60% of Predisability Earnings	180 Calendar days
50% of Predisability Earnings	180 Calendar days

The maximum monthly LTD benefit is $10,000. The minimum monthly LTD benefit is the greater of:
- $100; or
- 10% of your scheduled monthly benefit.

Total Disability

"Totally Disabled" or "Total Disability" means that, due to sickness or accidental injury, you are receiving appropriate care and treatment from a doctor on a continuing basis, and

- During the first 24-month period following your elimination period, you are not able to perform the material duties of your own occupation because of illness, injury or disabling pregnancy-related condition, and your earnings during that period are 80% or less of your Predisability Earnings (as defined below); or
- After the first 24-month period following your elimination period, you are not able to earn more than 80% of your Predisability Earnings from any employer in your local economy at any gainful occupation for which you are reasonably qualified because of illness, injury or disabling pregnancy-related condition.

For purposes of the above provisions, the term "adjusted Predisability Earnings" means your Predisability Earnings, increased annually for purposes of determining whether you continue to be Totally Disabled and for calculating any return to work assistance benefits. Increases will be applied after you have been Totally Disabled and have received LTD benefits for 12 months. The amount of the annual increase will be equal to the percentage increase in the Consumer Price Index (i.e., the CPI-W published by the U.S. Department of Labor) for the prior year, up to a maximum increase of 10% per year.

The Claims Administrator, in its sole discretion, will determine whether you are Totally Disabled and when you are eligible to commence or otherwise continue to receive LTD benefit payments. For purposes of determining whether a disability is the direct result of an accidental injury, the disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes. If Your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute Total Disability.

If, after the earlier of (i) the 24 month period following your elimination period or (ii) the date described in the "Duration of LTD Benefits" section below, the Claims Administrator determines that your Total Disability is primarily caused by a mental health or psychiatric condition (including physical manifestations of these conditions, but excluding conditions with demonstrable, structural brain damage, alcohol or drug abuse, neuromuscular disorder, musculoskeletal disorder, soft tissue disorder, or chronic fatigue syndrome), you will no longer be considered Totally Disabled unless you are confined as an inpatient in a hospital or licensed treatment facility. If inpatient confinement lasts less than 30 calendar days, you will no longer be Totally Disabled once your confinement ends. If your inpatient confinement last 30 calendar days or more, you will be considered Totally Disabled until 90 calendar days after the date your confinement ends.

Predisability Earnings

The LTD Benefit provides you with a monthly payment based on your Predisability Earnings. For salaried Employees, "Predisability Earnings" means your base annual earnings as of your last day of active work before your disability began, excluding bonuses, overtime, contributions made by the Company to any deferred compensation arrangement, revenue sharing, allowances, stipends, relocation incentives, buyouts of unused vacation, professional fees, or non-qualified income. For hourly Employees, "Predisability Earnings" means your hourly rate of pay multiplied by the number of hours you are regularly scheduled to work per month during the last 12 calendar months but not more than 173 hours per month.

Off Sets

Your monthly LTD benefit amount is reduced by any amounts you may receive from certain other sources, including:

- benefits under the federal Social Security Act (except as provided below) and Railroad Retirement Act;
- a Company insurance policy;
- a government compulsory benefit plan or program which provides payment for loss of time from your job due to your disability, whether such payment is made directly by the plan or program, or through a third party;
- any sick pay, vacation pay or other salary continuation from the Company;
- workers' compensation;
- Occupational disease laws;
- up to 50% of the income received for disability under laws providing for maritime maintenance and cure; or
- any income that you receive from working while Totally Disabled to the extent that such income reduces the amount of your monthly LTD benefit as described in the "Adjustments to LTD Benefits if You Work While Totally Disabled" section, including but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.

Income from other sources will not include:

- cost of living adjustments that are paid under any of the above sources of other income;
- reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by you;
- veteran's benefits;
- individual disability income insurance policies;
- benefits received from an accelerated death benefit payment; or

• amounts rolled over to a tax qualified plan unless subsequently received by you while you are receiving LTD benefit payments.

The Claims Administrator may require proof of other income. The amount of your monthly LTD benefit will not be reduced by any increases in your offsetting benefits arising after your monthly LTD benefit payments begin (other than increases due to (i) the correction of an error, (ii) a change in the number of people in your family, or (iii) a change in the severity of your disability). The Claims Administrator may reduce your LTD benefits if the original calculation was based on estimated Social Security benefits.

An overpayment also occurs when a payment is made by the Claims Administrator that should have been made under another group plan. In that case, the Claims Administrator may recover the payment from one or more of the following:
• any other insurance company;
• any other organization; or
• any person to or for whom payment was made.

Adjustments made to LTD Benefits If You Work While Totally Disabled

The amount of your monthly LTD benefits may also be reduced if, while monthly LTD benefits are payable, you receive income from the Company or any other employer, employment, self-employment, or occupation for compensation or profit. Any income earned by working will be considered income for such purposes only if the sum of: (i) your adjusted benefit, (ii) the amount you earn from working and (iii) other income you receive exceeds 100% of your Predisability Earnings. The minimum monthly benefit will not apply.
If you continue to receive such additional income for more than 24 months after your elimination period, your monthly LTD benefit will be reduced by 50% of the monthly amount you earn from working.

Payment of Benefits

You are entitled to receive LTD benefits only if you become Totally Disabled on or after the effective date of your LTD Program coverage. LTD benefit payments will begin accruing on the day after your elimination period if you are Totally Disabled, provided you are under appropriate doctor's care. You must file a claim for this benefit no later than 90 days following the end of your elimination period or, if you cannot meet this deadline through no fault of your own, no later than one year (unless you are legally incapacitated).

Duration of LTD Benefits

50% Coverage Option
Your benefits will continue according to the following schedule, or until you are no longer Totally Disabled or no longer under a doctor's care, whichever occurs first:

Age at Disability	**Maximum Benefit Duration / Maximum Number of Monthly Benefits**
Less than 65	Later of to the end of the month in which you reach age 65 or 60 months
At least 65 but less than 70	30 months

At least 70 but less than 75	18 months
75 and over	12 months

60% Coverage Option
Your benefits will continue according to the following schedule, or until you are no longer Totally Disabled or no longer under a doctor's care, whichever occurs first:

Age at Disability	**Maximum Benefit Duration / Maximum Number of Monthly Benefits**
Less than 62	To the end of the month in which you reach age 65
At least 62 but less than 63	42 months
At least 63 but less than 64	36 months
At least 64 but less than 65	30 months
At least 65 but less than 66	24 months
At least 66 but less than 67	21 months
At least 67 but less than 68	18 months
At least 68 but less than 69	15 months
69 and over	12 months

Survivor Benefit

If you die after receiving (or were eligible to receive) LTD benefits, a benefit equal to three times your monthly LTD benefit amount will be paid in a lump sum to your survivor. If you die before you were eligible to receive a full month of LTD benefits, a benefit equal to three times your monthly LTD benefit amount, not reduced by any other income benefits, will be paid in a lump sum to your survivor. Your survivor is your spouse or your Qualified Domestic Partner, or, if you have no spouse, or Qualified Domestic Partner, your child or children under age 26. If you have no survivors, this benefit will be paid to your estate.

Social Security Assistance Program

If you are approved for LTD benefits, the Claims Administrator offers the following services to assist you with your Social Security disability benefits:
• Assistance with the Social Security application process;
• Guidance through the appeal process by Social Security specialists; and
• Referrals to attorneys who specialize in Social Security law. (The Social Security approved attorney's fee will be credited to the LTD overpayment, which results upon receipt of the retroactive Social Security benefits.)

Early Intervention Program

A voluntary Early Intervention Program is offered to all Participants. The Early Intervention Program helps identify early those employees who might benefit from vocational analyses and rehabilitation services before they

are eligible for LTD benefits. Early rehabilitation efforts are more likely to reduce the length of your LTD and help you return to work sooner than expected.
If you cannot work, or can only work part-time due to a disability, the Company will notify the Claims Administrator, which may provide any of the following services:
• Reviewing and evaluating your disabling condition, even before a claim for LTD benefits is submitted (with your consent);
• Designing individualized return to work plans that focus on your abilities, with the goal of return to work;
• Identifying local community resources;
• Coordinating services with other benefit providers, including: medical carrier, short term disability carrier, workers' compensation carrier, and state disability plans;
• Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).

Rehabilitation Incentives

If you work while you are receiving LTD benefits, your monthly benefit will be increased by any approved rehabilitation program incentive (as described below) and reduced by other income (as provided above). Your monthly LTD benefit, as adjusted, will not be reduced by the amount you earn from working unless the sum of (i) your adjusted benefit, (ii) the amount you earn from working and (iii) any other income you receive exceeds 100% of your Predisability Earnings. The minimum monthly benefit will not apply.

Approved Rehabilitation Program. The Claims Administrator retains the right to evaluate you for a rehabilitation program. If the Claims Administrator determines that you are able to participate in a rehabilitation program, the Claims Administrator may require participation. If you refuse to participate, your LTD benefit payments may end.

For purposes of the LTD Program, an "approved rehabilitation program" is a program that has been approved by the Claims Administrator for the purpose of helping you return to work. It may include, but is not limited to, your participation in one or more of the following activities:

• return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings; or
• on-site job analysis; or
• job modification/accommodation; or
• training to improve job-seeking skills; or
• vocational assessment; or
• short-term skills enhancement; v
• vocational training; or
• restorative therapies to improve functional capacity to return to work.

Work Incentive

You will receive an additional benefit equal to 10% of your monthly LTD benefit for each week in which you participate in an approved rehabilitation program (as determined by the Claims Administrator in its sole discretion on a nondiscriminatory basis).

Family Care Incentive

If you are a participant in an approved rehabilitation program (as provided in the "Approved Rehabilitation Program Incentive" section above), you may be eligible for an additional benefit of up to $400 per month for up to 24 months for the following expenses:

- If you have a dependent child under age 13 who lives with you and is either your biological child, Spouse's legally adopted child, or child for whom you are legal guardian, you are eligible for an additional child care benefit to cover the costs of a licensed day care provider who does not live in your residence and is not a member of your immediate family.
- If you have a dependent family member of any age who lives with you and is incapable of independent living due to a mental or physical handicap, you are eligible for an additional family care benefit to cover the costs of a care provider who is not a member of your immediate family

When New LTD Benefits May Begin

If you are receiving LTD benefits and return to work for fewer than 180 days but are again unable to work because of the same or related Total Disability, you will immediately resume LTD benefits.

If you return to work before the end of your elimination period for at least 45 consecutive work days from when your prior Total Disability ended, if you return to work after the end of your elimination period for six consecutive months, or if your new Total Disability is from an unrelated cause, you will have to complete a new elimination period before receiving new LTD benefits

Limitations and Exclusions

LTD benefits are not available for Disabilities caused, contributed to by, or resulting from

- war, whether declared or undeclared, or act of war, insurrection, rebellion;
- your active participation in a riot;
- intentionally self-inflicted injury;
- attempted suicide; or
- commission or attempt to commit a felony.

Preexisting Conditions

A preexisting condition is an illness, injury or pregnancy-related condition, for which you were treated, diagnosed, received treatment/services, or took prescriptions recommended by your physician during the three months prior to the effective date of your coverage or increase in your coverage. The Plan will not pay an LTD benefit for a disability that was caused or contributed to by a preexisting condition if the disability begins within the first 12 months of effective coverage.

If your Total Disability was caused by a preexisting condition and you elect to increase coverage, your LTD benefit will be limited to the monthly LTD benefit that was in effect for at least 12 months prior to your election. In other words, you have to be covered for at least 12 months under the increased coverage for the disability to be covered at that new level.

If your LTD benefit coverage ends because you stop active work and you return to work within six months of the date your coverage ended, the preexisting condition rules will apply to you as if your coverage had not ended.

Effects of Prior Coverage

"Prior coverage" refers to any group long term disability coverage provided by the Company that has been replaced by coverage under the LTD Program. Coverage under the LTD Program generally replaces and supersedes any prior coverage. However, the LTD Program will not pay benefits for a particular period of Total Disability if you are receiving, are eligible to receive, or would have been eligible to receive long term disability benefits under the prior coverage. Additionally, if you had prior coverage, different terms may apply to you regarding preexisting conditions and if you become Totally Disabled again due to a same or related condition that began while you had prior coverage. Please contact the UABC for additional information.

Workers Compensation

The insurance certificate(s) for the LTD Program do not replace or affect any requirement for coverage by workers' compensation insurance.

Mandatory Disability Income Benefits

For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico. The insurance certificate(s) for the LTD Program do not affect any requirement for any government mandated temporary disability income benefits law.

Met Life AMFA LTD

If you become disabled due to a sickness or accidental injury, you need to file a claim - Call MetLife at 1-888-825-3368
Before benefits begin, you must complete a 140-day waiting (elimination) period. Once you've completed the 140-day elimination period, MetLife will pay a benefit of 500/0 of your base monthly salary on your last day worked up to $1,800 per month reduced by benefits from other sources; i.e. sick payor any other salary continuation other than vacation pay, state-mandated disability benefits, group disability benefits, Social Security Disability Benefits, Occupational Disease Law, or Employer Retirement plans.

This plan covers a disability caused by sickness or accidental injury that occurs 24 hours a day regardless if you are at work.

A Pre-Existing Condition is:

A sickness or accidental injury in the 12 months before your MetLife LTD coverage takes effect for which you:

- received medical treatment, consultation, care, or services;
- took prescription medication or had medications prescribed; or
- had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment.

MetLife may begin paying benefits for a disability resulting from a Pre-existing condition 12 month after your effective date of coverage. "Totally Disabled" or "Total Disability" means that due to a sickness or accidental injury, you are receiving Appropriate Care and Treatment from a doctor on a continuing basis; and

1. during the first 24-month period, following your Elimination Period, you are unable to perform the

duties of any part of your normal job with the entity that is your Employer; or

2. after the first 24-month period, following your Elimination Period, you are unable to perform the duties of any job for which you are reasonably qualified taking into account your training, education and experience from an employer.

Pre-Existing Condition Limitation

A sickness or accidental injury in the 12 months before your MetLife L TO coverage takes effect for which you: received medical treatment, consultation, care, or services; took prescription medication or had medications prescribed; or had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment
MetLife will not pay benefits for a Disability resulting from a Pre-existing Condition if you have been Actively at Work for less than 12 consecutive months after the date your Disability insurance takes effect under this certificate.

Benefit limitation

Neuromusculoskeletal and soft tissue disorder unless there is objective medical evidence of seropositive arthritis; spinal tumors, malignancy, or vascular malformations; radiculopathies; myelopathies; traumatic spinal cord necrosis; or maculopathies: 24 months of benefit a member's lifetime.

Own Occupation

Own occupation means the activity that the employee regularly performs and serves as his/her source of income. It may be a similar activity that could be performed with the employee's Company or any other employer in the employee's local economy.

Benefit offsets

Social Security or similar laws
State-mandated disability benefits
Workers' Compensation or similar law
Sick or any other salary continuation other than vacation
Employer retirement plans
Group disability plans
Occupational disease laws

If you are working while Totally Disabled, your Monthly Benefit will only be reduced by 50% of your employment earnings.

Return to Work Incentive

Let's say your pre-disability earnings were $2,500 per month making the base monthly benefit you would receive from the MetLife AMFA LTD plan $1,250. Since, for the first 24 months of disability, you need to be able to perform the functions and duties of your current job with United, it may be possible for you to perform in another role on a part-time basis. If you do return to work at a reduced wage of $800 per month, the monthly benefit for the first 24 months would be calculated as follows:

$1,250 (base benefit) + $800 (return to work earnings) = $2,050 per month (total monthly earnings)

Your total monthly earnings ($2,050) arc less than the pre-disability earnings ($2,500). This means that because your return to work earnings plus the base benefit do not exceed the pre-disability earnings of $2,500 per month, the
base benefit would remain the same and return to work earnings would not become an offset.

Now, after 24 months, it has been determined that you are still disabled based on the definition of disability. However, 50% of your return to work earnings will now become an offset to your MetLife AMFA LTD monthly
benefit. Hers is the calculation:

$800 (return to work earnings) / 2 (50%) = $400.00

$1,250 (base benefit) - $400 (50% of return to work earnings) = $850 per month (new base benefit).

Health Reimbursement Account (HRA/RHA)

As part of your benefits, United will establish a Health Reimbursement Account ("Active HRA Plan") or a separate Retiree Health Account ("RHA Plan"). Which plan you are eligible for is based on your current United medical benefits election (i.e. enrolled in an active medical plan or not).

Both accounts, which might be known to you collectively as the "VEBA", are provided for all eligible IBT represented employees.

We've put together some common questions to help you understand the benefit offered to you. If you have questions that are not answered here - contact the United Airlines Benefits Center (UABC) at 1-800-651-1007. Representatives are available Monday – Friday, 7:00 a.m. – 7:00 p.m. Central Time, except holidays.

When and how are funds contributed to my HRA?

For each compensable hour per pay period, United will contribute $1.20.

- If you are enrolled in a United Airlines medical plan, the United employer contributions ("contributions") will be deposited each pay period into your **Active HRA.**
- If you are not currently enrolled in a United medical plan, the contributions will be deposited each pay period into your **RHA** for future use (RHA contributions are unavailable for use until you leave or retire from United).
- Contributions will be available in your account within a few days following each pay day.
- Determination of where contributions will be deposited (Active HRA or RHA) is based on your medical plan enrollment on each pay day.
- Your pay stub will show both the current earnings each pay period as well as a year-to-date total of the contributions made by United into your account. Remember, the amounts shown on your pay stub will reset each January 1st.

Investment Earnings

In addition to the contributions each pay period, the value of your account will be adjusted quarterly based on the overall investment performance of the plan. Performance by the plan as a whole will be allocated amongst all of those participating in the plan at the time investment performance is reported to Your Spending Account (YSA). In accordance with the collective bargaining agreement, assets in the VEBA are invested conservatively to protect principal, but it is still possible for the fund to lose value. Earnings are added to accounts only in whole

increments of 1¢. Fractional earnings are not added; they are carried forward and evaluated when future earnings occur.

How do I find out my account balance?

- Use the Your Spending Account (YSA) Reimburse Me® mobile app.
- Log onto the YSA portion of Your Benefits Resources® (YBR) and your current account balances are shown on the landing page. Navigate to the YSA page through YBR at Flying Together > Employee Services > Health & Insurance (YBR).
- You can also hear your account balances within our automated phone system.

Active HRA

What is the Active HRA?

- As an active employee of the United IBT technicians group enrolled in a United medical plan, you are provided an Active HRA.

- Funds from United are deposited each payroll period on your behalf into your HRA. The account funding may be used for a variety of eligible healthcare expenses including helping to offset any costs for United medical premiums already deducted from your paycheck.

In general, reimbursements for eligible expenses are those items or services which treat, mitigate, prevent or cure specific injury, illness or disease. This includes expenses incurred outside the U.S. (as long as the expense is eligible in the U.S.). Cosmetic procedures and items used for general good health (such as dietary supplements) are not eligible. Under the Patient Protection and Affordable Care Act of 2010, over-the-counter medicine purchased is not reimbursable unless you receive a prescription (1) from an authorized health care provider. Health care supplies (for example, bandages or contact lens solution) are eligible without a prescription.

(1) For these purposes, a prescription means a written or electronic order for a medicine that meets the legal requirements of a prescription in the state in which the expense is incurred and is issued by a legally authorized individual in that state.

Eligible reimbursements may include:

- Doctor's office copays
- Prescriptions
- Health Care deductibles & coinsurance amounts
- United sponsored active medical plan premiums

Important Notes about Active HRA Reimbursements

Only eligible expenses for you and your covered dependents on your United medical plan can be reimbursed from your Active HRA. Pursuant to federal law, if your dependents are not covered by your United medical plan, their health care expenses **cannot** be reimbursed by the Active HRA.

The Active HRA cannot be used to pay for life insurance, long term care insurance or any other non-United medical insurance premiums, or costs for continuation of coverage. If you're enrolled in the Core HDHP or Healthy Advantage HSA medical plans with United, the Active HRA may only reimburse you for dental & vision expenses (and not medical and prescription). This is because you have your HSA in those accounts to use for medical and prescription expenses.

Several ways to get paid

- Premium offset
- YSA card
- Automatic reimbursement
- Submitting claims Online/Mobile App

How do I get reimbursed for my United medical premiums?

To receive reimbursements for some of what you pay for your United medical plan premium, if the coverage is provided under your benefits account, we offer the convenience of having Your Spending Account automatically issue you a payment for the premium amounts you paid.

If you're eligible (2) and enrolled in a qualifying plan, you will have the opportunity to request we automatically issue you a reimbursement for your United medical premiums that come directly out of your paycheck.

Important Note: If you're enrolled in one of the two medical plans with HSA that your active HRA will be limited purpose—and what that means.

Q: When will I be reimbursed?

A: Payments are issued at the first of the month following coverage.

Example: You are reimbursed in early May for premium amounts you paid in April.

Q: How do I start?

A: Call the United Airlines Benefits Center (UABC) at 800-651-1007 to add or remove the request for premium reimbursement anytime as long as you make the change prior to the last business day of the month. Example: Changes for July payments must be made before July 31st. Note: the UABC is open Monday thru Friday from 7 a.m. to 7 p.m. CST.

Q: What is the amount of my reimbursement?

A: We can only reimburse you up to the premium amount taken from your paycheck, or the available balance in your Active HRA, whichever is less. This means if you do not have a balance at the time the automatic premium request is processed, a claim will not pay. When this occurs, you will not receive notification of denial. Sometimes, due to timing of when a claim is received and paid and when your next contribution deposited, your reimbursement amounts may vary.

Example:

- You receive $96.00 for compensable hours on the most recent payroll cycle.
- You now have a balance of $96.00 in the Active HRA.
- You submit a claim for $40.00 and are reimbursed $40.00.
- YSA loads a claim for medical premium amount of $429.05.
- When approved the premium claim will only pay $56.00 as this is all that is now available in the account until calculation of compensable hours for the next payroll cycle and additional allocations are placed into the account.

(2) Those in the core or Healthy Advantage HDHP and on direct bill are not eligible for automatic payments

Q: How will I be paid?

A: If you are eligible and request to have us reimburse you for your United medical plan premiums, you will receive a check or direct deposit from us, regardless of how you're getting reimbursed for your health care service expenses.

If you didn't choose to have us automatically send your premium reimbursements, you may file directly on the YSA website. You won't need to submit any documentation with your claim. YSA will validate your request using your enrollment information in our system.

If you are covered by your spouse's medical coverage through United and you want the premiums reimbursed, you may request reimbursement by submitting a claim to YSA. We regret we cannot offer automatic reimbursement of premiums when your United coverage is provided under your spouse's record.

How the Process Works

If you are eligible and make the election to have your medical premiums automatically paid back to you and;

- You make that election before the last business day of the month.
- YSA will generate a payment on the 6th (or next business day thereafter) of the next month. For example, reimbursements for April will be issued in May.
- If you decide in May that you no longer want YSA to automatically reimburse your premium, you have to notify the UABC by the end of May.

Important Notes on Premium Offset Timing

Payments are issued at the beginning the month following coverage (for example, you are reimbursed in early May for premium amounts you paid in April). Participants will be able to call the United Airlines Benefits to add or remove the request for premium reimbursement anytime as long as the change is made prior to the end of the month, (for example changes for July payments must be made before July 31st). Participants must notify the UABC at 1-800-924-3967 by the end of the month prior to stop automatic reimbursement.

Will YSA send a check? How will I receive my money?

- For your health care services expenses (for example, doctor office visit & pharmacy expenses), you may choose one of two options:

Automatic Reimbursement: When you seek care under your United sponsored health plan, you'll pay your provider for any eligible out-of-pocket expenses. As soon as your health plan submits claims to YSA, you'll be directly reimbursed with no need to complete any paperwork. If you're enrolled in a United medical plan, automatic reimbursement is an easy and convenient way to get reimbursed for your health care services. Automatic reimbursement is available from these health insurance companies:

- Aetna
- Anthem Blue Cross
- Blue Cross Blue Shield
- MetLife Dental
- VSP
- CVS
- Beacon Health

Certain health plans (for example, Kaiser, HMSA, Superior Vision, NetCare) do not participate in the automatic reimbursement process. You will need to to submit directly to YSA for reimbursement if you're covered by a plan who doesn't participate in the automatic reimbursement process.

The YSA Card:

- You can use the YSA Card to pay for eligible out-of-pocket expenses at the time of purchase and funds will automatically be deducted from your YSA account.
- The YSA Card can be used at any health care provider or merchant (for example, pharmacies, hospitals, doctor's offices) who are authorized to accept spending account cards.
- You may need to submit receipts to verify certain expenses. A credit card authorization receipt is not a valid expense receipt.
- Your receipt must be itemized with claim information.

- Receipt requirement information along with examples of what is needed can be found in the Knowledge of the YSA website.
- For those enrolled in the Core HDHP & Healthy Advantage HSA medical plans with United, only dental and vision expenses can be reimbursed from your Limited Purpose Health Care Flexible Spending Account and/or your Limited Purpose Active HRA. Due to this, you are not eligible for a YSA Card.

With either option, you can still always submit claims for reimbursement of eligible expenses directly to YSA. Examples when you might need to do this -- if you elected the YSA Card option but paid by cash or check for a particular purchase, or, you elected the Automatic Reimbursement option but incurred an expense outside of your health plan coverage. If you prefer to submit all of your claims directly to YSA please call us – we can turn off your automatic reimbursement without issuing you a YSA Card.
Important Note: Remember, you can only choose YSA card **or** Automatic Reimbursement - not both.
If you're new to YSA, you'll initially be set up with automatic reimbursement. If you would like a YSA Card, or if you'd like to change your reimbursement method, after your first contribution is made to your HRA, login to Your Benefits Resources® and change your choice election to YSA Card. Information on how to process your request will be included in your welcome notification sent after the close of the special enrollment period.

If you have a HCFSA and past reimbursement choice
If you already have a Health Care Flexible Spending Account with YSA, or have participated in the HCFSA in the past, your prior reimbursement choice will apply to any new benefits added. If you want to change your reimbursement method, from the YSA landing page, select "Edit Your Profile". The reimbursement option is in the upper right corner.(3)

I currently have a YSA Card, will I get a new one?
If you currently have a YSA Card because you're in the Health Care Flexible Spending Account, you will not receive a new card. Any new benefits (for example, the Active HRA or Healthy Rewards HRA), will be added to your existing card.

I've never had a YSA Card
Should you decide the YSA Card is the way to go for you, here are a few important things to keep in mind: **Save Your Receipts!** The IRS requires that every YSA Card transaction be validated. YSA will make every effort to validate your transactions without action from you. We use a variety of processes to validate your transactions, such as using information from your health plan, point of sale verification systems, and matching to United plan copays. If we're unable to validate your transactions within 30 days, we will send you a request to provide supporting documentation. In order to substantiate that your transaction is for eligible expenses, you'll need to submit detailed, itemized receipts for your purchases.
Your receipts must include the following information:
• Name of service provider or retailer
• Date of service or purchase
• Identification of drug or product, or description of service
• Purchase amount for each product or service
• Total purchase amount
Although other documentation can be used, most often submitting the Explanation Of Benefits (EOB) from your health insurance provider is the easiest way to validate your YSA Card transactions.
It's important to submit acceptable supporting documentation when requested. When transactions are not validated, your YSA Card may be suspended. Undocumented transactions may result in tax implication

(3) To avoid the potential of duplicate reimbursements, you may change your reimbursement method twice each year.

I chose the YSA Card – can I request additional cards for my spouse/dependents?
Yes, once you receive your YSA Card, you may request additional cards for your spouse and/or dependents by visiting Your Benefits Resources® à Other Benefits à Spending Accounts.

How do I receive claim information from YSA?
The fastest & easiest way to get notifications about your claims – for example, the outcome of a claim you've submitted or when you need to provide documentation for a YSA Card transaction – is to sign up for text alerts and use the YSA Reimburse Me® mobile app. If you have an email address on file, you will be notified electronically of important account information. We will mail account information to you if you don't have an email on file. At any time you can always request we mail you information on how your claims were processed.

Where do I go for more information?
For more information about the YSA Card including where you can use it, what documentation you may need to submit for various types of reimbursement requests, how your plan works, when premium offsets are processed and more – visit the YSA Knowledge Center (through Your Benefits Resources - Other Benefits - Spending Accounts). If you have a question for which you can't find an answer, choose "Secure Mailbox" in the upper right corner and send us an email.

What happens if both my spouse & I work for United?
If you and your spouse both work for United, special rules may apply.

- If you're both eligible for United contributions - you will separately receive contributions into your Active HRAs or RHA, as applicable.
- As long as you are covered by a United medical plan – even if your spouse covers you under their United benefits – your contributions will go into your Active HRA.
- Automatic reimbursements of medical premiums from your Active HRA are only available when you carry the medical coverage. If your spouse provides the coverage (i.e., you are listed as the spouse on your spouse's United coverage), and you want your medical premiums reimbursed from your Active HRA, you must submit them directly to YSA. Please note, if your spouse covers you under the Core HDHP or Healthy Advantage HSA, you cannot be reimbursed for your medical premiums.
- Collectively, you may have several different spending account plans available to you for reimbursement of your health care expenses – a specific item can only be reimbursed from one eligible plan. For example, you both cannot submit the same doctor's visit under different plans for payment.

Retiree Health Reimbursement Account (RHA)
How does the RHA work?
When you leave United your participation in the Active HRA ends and your YSA Card will be suspended (if you have one). You will have 60 days to submit any of your claims for when you were covered by the Active HRA to YSA. After that 60 day run-out period, YSA will transfer your remaining Active HRA funds to your RHA. At that time, your YSA Card will be reactivated under the RHA loaded with the transferred funds. If you had funds in your RHA already (for example, because you didn't take United medical coverage for a time), the balance will be the combination of funds already in your RHA plus the available balance transferred from your Active HRA. At the time you leave or retire from United, the funds in your RHA may be used to reimburse health care expenses (doctor's office copays, deductibles & coinsurance amounts – medical, dental, vision, hearing & prescriptions are all covered), as well as reimburse you for after-tax health care insurance premiums. Eligible reimbursements may include premium payments for:

- United retiree health insurance
- Individual health insurance
- Other employer retiree group plans

- COBRA premiums
- Medicare & Medigap
- Long-term care

A list of eligible expenses and the documentation you'll need to provide in order that we can pay your claim will be available on the Knowledge Center of the YSA website. With the RHA, you'll still have the option of a YSA Card to use for your health care services (insurance premiums cannot be paid with the card). You'll also have the option to set a recurring claim. With a recurring claim, you establish your premium amount the first time you submit and then we'll automatically issue you a payment each month. You can start, stop, or change your automatic premium reimbursement at any time online; new amounts will require you to supply new documentation. Information on how to set up a recurring claim, and the necessary documentation required, is available on the YSA website after your RHA is established with us.

Where can I find a list of more eligible expenses?
You can visit the Knowledge Center in the YSA portion of Your Benefits Resources®. You'll find helpful information about how your account operates, including what's eligible under the different plans, and what documentation is required to validate your claim as an eligible expense.
In general, reimbursements for eligible expenses are those items or services which treat, mitigate, prevent or cure specific injury, illness or disease. This includes expenses incurred outside the U.S. (as long as the expense is eligible in the U.S.). Cosmetic procedures and items used for general good health (such as dietary supplements) are not eligible. Under the Patient Protection and Affordable Care Act of 2010, over-the-counter medicine purchased is not reimbursable unless you receive a prescription4 from an authorized health care provider. Health care supplies (for example, bandages or contact lens solution) are eligible without a prescription.

For these purposes, a prescription means a written or electronic order for a medicine that meets the legal requirements of a prescription in the state in which the expense is incurred and is issued by a legally authorized individual in that state.

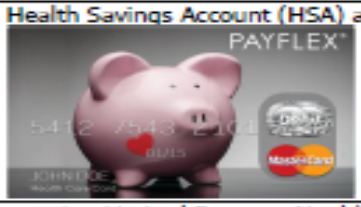
Should I designate beneficiaries on my HRA?
You are able to designate beneficiaries for both your Active HRA and your RHA by calling the United Airlines Benefits Center (UABC).

Q: Who can I designate as a beneficiary?
A: Your spouse/qualified domestic partner is automatically your primary beneficiary. If your spouse/qualified domestic partner dies or remarries, or if you do not have a surviving spouse/qualified domestic partner, you may designate your surviving dependent children who were listed on your account as beneficiaries and provide if they should receive it equally or by a designated percentage to each. This has to be in accordance with Section 152 of the IRS code (that is, they must qualify as tax dependents under the IRS rules).

Q: What happens if I don't name beneficiaries?
A: If you die, your surviving spouse/qualified domestic partner is automatically your beneficiary (regardless of whether you file a beneficiary designation form). If your spouse/qualified domestic partner dies or remarries, or if you do not have a surviving spouse/qualified domestic partner, any remaining balance in your account will be divided into separate sub-accounts for each of your surviving dependent children who were designated by you. If you did not file a beneficiary designation, each of your surviving children who were dependents immediately prior to your death will become a beneficiary. There are no other default beneficiaries under the Plan. Once you and all of your surviving spouse/qualified domestic partner and dependents have died or ceased to be eligible, the remaining portion of your account will be forfeited and re-allocated per capita among the accounts of the remaining participants in the plan.

Q: Can I leave it to my children, not my spouse/qualified domestic partner?
A: No. Your spouse/qualified domestic partner is automatically your primary beneficiary and cannot be bypassed in favor of your dependent children. However, your spouse/qualified domestic partner may choose to use the account exclusively for your eligible dependent children's expenses.

From which account will my claims be reimbursed?
How eligible expenses for your health care services are paid will depend on your medical plan election and spending accounts in which you are participating. The below charts presume you are participating in every spending account available to you and you're covered by a United medical plan.
If you are enrolled in the **Core HDHP or the Healthy Advantage HSA (Health Savings Accounts for both plans are administered by PayFlex),** in keeping with federal guidelines, your (yours and those of your eligible dependents) medical and prescription eligible expenses must be reimbursed from your Health Savings Account.

Medical Services & Prescription Expenses:	Health Savings Account (HSA) administered by PayFlex 
Dental & Vision Expenses:	1. Limited Purpose Health Care Flexible Spending Account (LPHCFSA)* 2. Limited Purpose Active HRA (LPHRA)* **For more information on Limited Purpose accounts, please refer to the glossary*
Active United Medical Plan Premiums:	The costs (premiums and claims) of your United HDHP medical plan cannot be reimbursed because you are also enrolled in an HSA. This is pursuant to IRS federal rules.

If you are enrolled in the **Healthy Rewards PPO:**

Medical Services & Prescription Expenses:	1. Health Care Flexible Spending Account 2. Healthy Rewards HRA 3. Active HRA
Dental & Vision Expenses:	1. Health Care Flexible Spending Account 2. Active HRA
Active United Medical Plan Premiums:	Active HRA

If you are enrolled in **any other United medical plan:**

Medical, Dental, Vision Services, & Prescription Expenses:	1. Health Care Flexible Spending Account 2. Active HRA
Active United Medical Plan Premiums:	Active HRA

If you are **not** enrolled in a United medical plan and are an active employee:

Medical, Dental, Vision Services, & Prescription Expenses:	1. Health Care Flexible Spending Account

Once you leave United:

Medical, Dental, Vision Services, & Prescription Expenses as well as after-tax health care premiums:	1. RHA

Are there important dates I need to remember?
Yes! Although your unused HRA funds roll over each year, your expenses must be submitted timely to be considered for reimbursement. This chart outlines the applicable deadlines for the various United spending account plans:

Plan	Deadline to incur expenses	Deadline to submit expenses	What happens if I miss the deadline?
Active HRA – *while working for United*	January 1 through December 31 each year *For example 12-31-2018*	April 30 of the following year *For example 04-30-2019*	Unused funds are available for future use but we cannot pay for prior year services
Active HRA – *after I leave United*	Last day of work with United	60 days from the day you leave United	Unused funds will be transferred to the RHA
RHA	Eligible expenses are those received within the prior 180 days	180 days from the date the expense was incurred	Unused funds are available for future use but we cannot pay for services which occurred more than 180 days in the past
Healthy Rewards HRA	December 31 each year *For example 12-31-2018*	April 30 of the following year *For example 04-30-2019*	Unused funds are available for future use but we cannot pay for prior year services
Health Care Flexible Spending Account	January 1 through March 15 *For example 01-01-2018 through 03-15-2019*	April 30 of the following year *For example 04-30-2019*	Unused HCFSA funds are forfeited

United Flying Together credentials). Once signed in choose the Profile icon, then Direct Deposit. Enter the requested information to complete the sign up process.

To set up direct deposit online, access the United Airlines Benefits Service Center via from the Your Benefits Resources® (**Flying Together > Employee Services > Health & Insurance (YBR)> Other Benefits > Spending Accounts**). From the Take Action section select "Edit Your Profile". In the Direct Deposit Information on the bottom left side, choose "Add" and follow the prompts to enroll.

AFLAC

WHOLE LIFE INSURANCE

Benefits:

- Benefit amounts are available up to $300,000 for members, up to $100,000 for spouses and up to $25,000 for dependent children.
- Guaranteed Issue Face amount is $100,000 for member and $50,000 for spouse.
- Waiver of Premium Benefit (employee only).
- Accidental-Death Benefit (employee and spouse only).
- Accelerated Benefit Rider (employee and spouse only)

Features:

- Premiums will never increase.
- Benefits may be paid directly to your named beneficiary.
- Coverage is portable (with certain stipulations), which means you can take it with you if you change jobs or retire.
- Premiums are paid through convenient payroll deduction.
- Policy builds cash value for you and your family.

Benefits Overview

WHOLE LIFE BENEFIT (Employee, Spouse, Child and Grandchild (see eligibility) coverage available)
The Whole Life Benefit pays proceeds upon the insured's death. Proceeds are defined as the total of the benefits payable upon the insured's death. Proceeds will be the sum of the amount of insurance in force, any insurance on the life of the insured provided by benefit riders, any premium paid that applies to a period of time beyond the certificate month in which the insured dies, less any certificate loan and loan interest, and any unpaid premium, except the first premium, that applies to a period before and including the certificate month in which the insured dies.

ACCELERATED BENEFIT RIDER (Employee and Spouse only)
The Accelerated Benefit Rider pays a lump sum benefit up to one-half of the eligible death benefit when the insured is diagnosed with one or more Qualifying Life Events.

The insured may choose the amount of the Accelerated Benefit, subject to these limitations: The maximum Accelerated Benefit is 50% of the eligible death benefit subject to state limitations. Refer to your certificate for benefit details. The insured may also choose to take the Accelerated Benefit as a monthly benefit. See certificate for details.

ACCIDENTAL DEATH BENEFIT RIDER (Employee and Spouse only)
The Accidental Death Benefit Rider provides an additional benefit equal to the face amount if the insured dies within 90 days of direct accidental bodily injuries. The maximum coverage available under this rider is $300,000. Employees and spouses, ages18-60, are issued this benefit, which terminates at age 65.

WAIVER OF PREMIUM BENEFIT RIDER (Employee only)
The Waiver of Premium Benefit Rider waives entire premium amount for employee coverage after the insured has been totally disabled due to bodily injury or disease for 4 consecutive months and continues throughout the duration of the disability. Any recurrence of a prior disability will be covered, provided the prior disability continued for at least 6 consecutive months, began within 30 days of recovery, and was due to the same or related causes. The Waiver of Premium Benefit Rider is also available for loss of sight or loss of limbs even though the employee may be able to engage in an occupation. Only employees, ages 18-55, are eligible to be issued this benefit, which terminates at age 60.

CHILDREN'S TERM INSURANCE RIDER (Children only)
The Children's Term Rider pays a benefit upon receipt of due proof of death of an insured child if coverage is in force, it is before the expiration date, and it is before the rider anniversary following the insured child's 26th birthday. The children's term insurance may be converted to a whole life plan without evidence of insurability subject to the maximum shown in the certificate. Refer to your certificate for details.

CRITICAL ILLNESS ADVANTAGE

Benefits:

- Benefits are paid directly to you, unless otherwise assigned.
- Guaranteed Issue Amounts
- No Waiting Period
- No Pre-Existing Condition Exclusion

Eligible Amounts:

- Member: Up to $50,000
- Spouse: Up to $25,000

Guaranteed-issue Amounts:

- Member: Up to $30,000
- Spouse: Up to $15,000
- Children: Up to $15,000

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
SUDDEN CARDIAC ARREST	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SEVERE BURNS*	100%
COMA**	100%
PARALYSIS**	100%
LOSS OF SIGHT / HEARING / SPEECH**	100%
AMYOTRPHIC LATERAL SCLEROSIS[1] (ALS or Lou Gehrig's Disease)	100%
SUSTAINED MULTIPLE SCLEROSIS[1]	100%
BENIGN BRAIN TUMOR[2]	100%
ADVANCED ALZHEIMER'S DISEASE[2]	100%
ADVANCED PARKINSON'S DISEASE[2]	25%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

1. These benefits are found in the Progressive Diseases rider. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.
2. These benefits are found in the Optional Benefits rider. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

INNITIAL DIAGNOSIS
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 3 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 3 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

CHILD COVERAGE AT NO ADDITIONAL COST
Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

SKIN CANCER BENEFIT
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

WAIVER OF PREMIUM
If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

SUCCESSOR INSURED BENEFIT
If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amont and would also include any dependent child coverage in force at the time.

HEALTH SCREENING BENEFIT (Employee and Spouse only)
We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for heath screening tests performed as the result of preventative care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TEST INCLUDES:

- **Blood test for triglycerides**
- **Bone marrow testing**
- **Breast ultrasound**
- **CA 15-3 (blood test for breast cancer)**
- **CA 125 (blood test for ovarian cancer)**
- **CEA (blood test for colon cancer)**
- **Chest X-ray**
- **Colonoscopy**
- **DNA stool analysis**
- **Fasting blood glucose test**
- **Flexible sigmoidoscopy**
- **Hemocult stool analysis**
- **Mammography**
- **Pap smear**
- **PSA (blood test for prostate cancer)**
- **Serum cholesterol test to determine level of of HDL and LDL**
- **Serum protein electrophoresis (blood test for myeloma)**
- **Spiral CT screening for lung cancer**
- **Stress test on a bicycle or treadmill**
- **Thermography**

ACCIDENT INSURANCE

Benefits Overview	BENEFIT AMOUNT
INITIAL TREATMENT (once per accident, within 7 days after the accident, not payable for telemedicine services)	Up to $200
AMBULANCE (once per day, within 90 days after the accident)	Up to $900
MAJOR DIAGNOSTIC TESTING (once per accident, within 6 months after the accident)	$150
EMERGENCY ROOM OBSERVATION (within 7 days after the accident)	Up to $70
PRESCRIPTIONS (2 times per accident, within 6 months after the accident)	$5
BLOOD/PLASMA/PLATELETS (3 times per accident, within 6 months after the accident)	$200
PAIN MANAGEMENT (once per accident, within 6 months after the accident)	$75
CONCUSSION (once per accident, within 6 months after the accident)	$350
TRAMATIC BRAIN INJURY (once per accident, within 6 months after the accident)	$3,500
COMA (once per accident)	$7,500
EMERGENCY DENTAL WORK (once per accident, within 6 months after the accident)	Up to $120
BURNS (once per accident, within 6 months after the accident)	Up to $15,000
EYE INJURIES	$175
FRACTURES (once per accident, within 90 days after the accident)	Up to $3,000 based on a schedule
DISLOCATIONS (once per accident, within 90 days after the accident)	Up to $2,000 based on a schedule
LACERATIONS (once per accident, within 7 days after the accident)	Up to $600
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in hospital or ambulatory surgical center within one year after the accident)	$35
FACILITIES FEE FOR OUTPATIENT SURGERY (surgery performed in hospital or ambulatory surgical center within one year after the accident)	$75
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident)	$35
INPATIENT SURGERY AND ANESTHESIA (per day / within one year after the accident)	$750
TRANSPORTATION (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident)	Up to $350

Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted du5 to an accidental injury.

AFTER CARE BENEFITS	BENEFIT AMOUNT
APPLIANCES (within 6 months after the accident)	Up to $300
ACCIDENT FOLLOW-UP TREATMENT (maximum Of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident)	$35
POST-TRAUMATIC STRESS DISORDER (PTSD) (once per accident, within 6 months after the accident)	$150
REHABILITATION UNIT (maximum of 31 days per confinement, no more than 62 days total per calendar year for each insured)	$75 per day
THERAPY (maximum of 10 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident)	$35
CHIROPRACTIC OR ALTERNATIVE THERAPY (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident)	$25
HOSPITALIZATION BENEFITS	
HOSPITAL ADMISSION (once per accident, within 6 months after the accident)	$1,000 per confinement
HOSPITAL CONFINEMENT (maximum of 365 days per accident, within 6 months after the accident)	$225 per day
HOSPITAL INTENSIVE CARE (maximum of 30 days per accident, within 6 months after the accident)	$300 per day
INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT (maximum of 30 days per accident, within 6 months after the accident)	$150 per day
FAMILY MEMBER LODGING (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident)	$150 per day
LIFE CHANGING BENEFITS	
DISMEMBERMENT (once per accident, within 6 months after the accident)	Up to $17,500
PARALYSIS (once per accident, diagnosed by a doctor within six months after the accident)	Up to $7,500
PROSTHESIS (once per accident, one replacement per device per insured)*	$2,000
RESIDENCE/VEHICLE MODIFICATION (once per accident, within one year after the accident)	$1,500
WELLNESS RIDER (once per calendar year)	Up to $75
CATASTROPHIC ACCIDENT RIDER (365-day elimination period)	Up to $250,000

* We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.

DISABILITY INSURANCE

The Aflac group disability plan benefits:

- Benefits are paid when you are sick or hurt and unable to work, with amounts up to 60% of your salary (up to 40% in states with state disability).
- Guaranteed-issue Minimum and Maximum Total Monthly Benefit- $300 to $6,000.
- 3 month and 5 month benefit options available.
- 30 Day Accident / 30 Day Sickness Elimination Period
- Premium payments are waived after 90 days of total disability (not available on 3 month benefit period).
- Partial Disability Benefit.

Features:

- Benefits are paid directly to you unless otherwise assigned.
- Coverage is portable. That means you can take it with you if you change jobs (with certain stipulations).
- Payroll Deduction- Premiums are paid through convenient payroll deduction.
- Fast claims payment. Most claims are processed in about four days.

Benefits Overview

TOTAL DISABILITY
This convenient, affordable disability income plan will help provide needed income if you become Totally Disabled and are unable to work due to a covered injury or illness. Total disability benefits will be payable monthly once the elimination period has been satisfied.

PARTIAL DISABILITY
The Partial Disability Benefit helps you transition back into full-time work after suffering a disability. If you remain partially disabled and are only able to work earning less than 80 percent of your pre-disability income at any job, this plan will still pay you 50 percent of your selected monthly benefit for up to the maximum partial disability benefit period of 3 months after the elimination period. You do not have to have received the Total Disability benefit to receive the Partial Disability benefit.

WAIVER OF PREMIUM
Premiums are waived after 90 days of Total Disability. After Total Disability benefits end, any premiums which become due must be paid in order to keep your insurance in force. This benefit is not available on plans with a 3-month benefit period.

CONTINUATION OF COVERAGE
If you cease employment with your employer, you may elect to continue your coverage. In order to continue your coverage you must meet all of the requirements listed below.

- You must work full-time for another employer.
- You must make a written application and pay the required premium to us within 31 days after the date your insurance would otherwise terminate.
- You must continue to pay any required premiums.

The coverage you may continue is that which you had on the date your employment terminated. If you qualify for this continuation of coverage as described, then the same benefits, plan provisions, and premium rate shown in

your certificate as previously issued will apply. Coverage may not be continued if you fail to pay any required premium or if the master policy terminates. Instructions for continuing coverage will be provided within your certificate of coverage.

WHOLE LIFE LIMITATIONS AND EXCLUSIONS

If an insured takes his own life within two years from the date of issue of his certificate, our liability will be limited to all premiums paid, without interest, less any certificate loan and loan interest.

ACCELERATED BENEFIT RIDER EXCLUSIONS

We will not pay the Accelerated Benefit until we receive proof of the insured's qualifying event and the following conditions are met: We have received the owner's written request for an Accelerated Benefit; We have received written consent from all irrevocable beneficiaries waiving their rights to any death benefit required to pay off the lien at the time of death.

At our discretion, we may require written consent from a spouse of the insured, or other beneficiaries, or any other person whom we believe to have a potential interest in the proceeds of the certificate; and We have received as assignment form making us the assignee of the certificate for the amount of the lien.

The rider is not intended to provide health, nursing, home or long term care insurance. Benefit payments may affect the insured's eligibility to receive Medicaid and other government benefits or entitlements.

Receipt of accelerated benefits may be taxable. The insured should consult with his personal tax advisor. This benefit is subject to an administrative expense charge not to exceed $150. We will not pay the Accelerated Benefit: If either the owner or the insured is required by a government agency to use the Accelerated Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement; If either the owner or the insured is required by law to use the Accelerated Benefit to meet the claims of creditors, whether in bankruptcy or otherwise; If the qualifying event results from intentionally self-inflicted injuries; If the certificate is in force as either extended term insurance or reduced paid-up insurance; If the certificate is legally or equitably assigned, except to us as security for the lien; If any part of the Death Benefit under the certificate is contestable; If the certificate is not in force or the Death Benefit under the certificate is not payable for any reason. If the amount of the Accelerated Benefit, plus the amount of all Accelerated Benefits on the insured from all certificates issued by us, exceeds $250,000; or If there has already been an Accelerated Benefit paid on the certificate.

ACCIDENTAL DEATH RIDER EXCLUSIONS

The Accidental Death Benefit provided will not be payable if the insured's death results from any of the following causes: War, or an act of war (including any armed aggression resisted by the armed forces of any country or combination of countries), whether such war is declared or undeclared; Suicide; Any bodily or mental infirmity (or disease, except a bacterial infection occurring with or through an accidental injury; Committing or attempting to commit an assault or felony; The voluntary taking of any drug, medication, or sedative unless as prescribed by a physician; or any poison (except for food poisoning), including carbon monoxide; Operating, riding in, or subsequent drowning from, any kind of aircraft, if the insured: Is a pilot, officer, or member of the crew; or Is giving or receiving any kind of training or instructions; or Has any duties aboard such aircraft, Skydiving

WAIVER OF PREMIUM RIDER EXCLUSION

No benefit will be provided by the rider if a total disability is caused by: An intentionally self- inflicted injury; or Results from an act of war (declared or undeclared) while the insured is in the military service of any country.

Approval for Waiver of Premium requires: That the total disability be caused by bodily injury or by disease; That the total disability has continued for four consecutive months; and That the rider and certificate were in force when the total disability began.

CHILDREN'S TERM INSURANCE RIDER EXCLUSIONS

The Children's Term Insurance Rider is part of the certificate and is subject to all certificate provisions that are not inconsistent with it. It is issued in consideration of the application for and the payment of premiums for this rider.

TERMS YOU NEED TO KNOW

Beneficiary means the person (or entity) named in the application, or later changed by the plan owner, who will receive proceeds upon the death of the insured.

Eligible Person means the following individuals who are eligible for coverage: 1. A person who is employed and paid for services by his employer on a regular basis. The eligible person must work for the employer: a. At such person's usual place of work, or such other places as required by the employer in the course of such work; b. For the full number of hours and full rate of pay, as set by the employment practices of the employer. 2. The employed person's spouse. 3. The employed person's child under 26 years of age. 4. A child under 26 years of age the eligible person will be adopting pursuant to an interim court order of adoption. 5. The employed person's grandchild under 26 years of age, who is legally dependent on the employed person. Note: "Child" as used above includes adopted children and stepchildren. However, eligible person will not include a foster child. An eligible child or grandchild must be under age 26 to be issued coverage, but whole life coverage under the certificate does not end after age 26.

Child eligibility definitions vary by state.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Total Disability means the incapacity of the primary insured, as a result of bodily injury or disease or mental disease, to engage, for remuneration or profit, in an occupation or profession. During the first 24 months of such disability, occupation or profession means the primary insured's occupation or profession at the time the disability began; thereafter it means any occupation or profession for which he is, or becomes, reasonably suited by education, training, or experience.

Eligible Death Benefit means the death benefit payable under the certificate and any riders by reason of death of the insured, not reduced by certificate loans excluding accidental death benefit riders, and any death benefit that is within five years of its expiration date on the benefit date.

Qualifying Event means one or more of the following: A non-correctable illness or physical condition that, with a reasonable degree of medical certainty, will result in the death of the insured in less than 12 months from the date of a written statement by a physician. A condition that causes the insured to lose the ability to perform, without substantial assistance from another person, at least two activities of daily living due to a loss of functional capacity. This condition must be expected to last for the rest of the insured's life. A condition which causes the Insured to require substantial supervision to protect himself from threats to health and safety due to severe cognitive impairment. This condition must be expected to last for the rest of the insured's life.

YOUR COVERAGE MAY BE CONTINUED

When an employee is no longer a member of an eligible class and coverage would otherwise terminate, coverage may be continued. See certificate for details.

CRITICAL ILLNESS LIMITATIONS AND EXCLUSIONS

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured: Is treatment-free from cancer for at least 12 months before the diagnosis date; and Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to: Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured; Suicide – committing or attempting to commit suicide, while sane or insane; Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job: Participation in Aggressive Conflict: War (declared or

undeclared) or military conflicts; Insurrection or riot Civil commotion or civil state of belligerence.Illegal Substance Abuse: Abuse of legally-obtained prescription medication Illegal use of non-prescription drugs. Diagnosis, treatment, testing, and confinement must be in the United States or its territories. All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases: Aplastic anemia, Congenital neutropenia, Severe immunodeficiency syndromes, Sickle cell anemia, Thalassemia, Fanconi anemia, Leukemia, Lymphoma, Multiple myeloma.

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

A malignant tumor characterized by: The uncontrolled growth and spread of malignant cells, and The invasion of distant tissue.

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

Melanoma that is Clark's Level III or higher or Breslow depth equal to or greater than 0.77mm, Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia), Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts), Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia). The following are not considered internal or invasive cancers: Pre-malignant tumors or polyps Carcinomas in Situ Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin Melanoma in Situ Melanoma that is diagnosed as Clark's Level I or II, Breslow depth less than 0.77mm, or Stage 1A melanomas under TNM Staging.

Non-Invasive Cancer is a cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of the plan, a Non-Invasive Cancer is: Internal Carcinoma in Situ Myelodysplastic Syndrome – RA (refractory anemia), Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts).

Skin Cancer, as defined in this plan, is not payable under the Non-Invasive Cancer Benefit.

Skin Cancer is a cancer that forms in the tissues of the skin. The following are considered skin cancers: Basal cell carcinoma, Squamous cell carcinoma of the skin Melanoma in Situ Melanoma that is diagnosed as Clark's Level I or II, Breslow depth less than 0.77mm, or Stage 1A melanomas under TNM Staging.

These conditions are not payable under the Cancer (internal or invasive) Benefit.

Cancer, non-invasive cancer, or skin cancer must be diagnosed in one of two ways: Pathological Diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This diagnosis must be made by a certified pathologist and conform to the American Board of Pathology standards. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if: A doctor cannot make a pathological diagnosis because it is medically inappropriate or life- threatening, Medical evidence exists to support the diagnosis, and A doctor is treating you for cancer or carcinoma in situ Complete Remission is defined as having no symptoms and no signs that can be identified to indicate the presence of cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force. In Illinois, critical illness is a sickness or disease that began while the insured's coverage is in force. In South Dakota, critical illness is a disease or a sickness that manifests while your coverage is in force.

Date of Diagnosis is defined as follows: Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs. Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). Coronary Artery Bypass Surgery: The date the surgery occurs. Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days. Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition. Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis. Loss

of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible. Major Organ Transplant:

The date the surgery occurs. Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). Paralysis: The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records. Severe Burn:

The date the burn takes place. Skin Cancer: The date the skin biopsy samples are taken for microscopic examination. Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies). Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, who is listed on your application. Dependent children are your or your spouse's natural children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26 (in Indiana, this includes children subject to legal guardianship). Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent (in Arkansas, chiefly dependent) on a parent for support. The employee or the employee's spouse must furnish proof of this incapacity and dependency to the company within 31 days (in Indiana, 120 days) following the dependent child's 26th birthday.

In Texas, this limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support and maintenance. Dependent Children may also include grandchildren, who are unmarried, under age 26, and if they are your dependents for federal income tax purposes, or if you must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that: Is made by a doctor and Is based on clinical or laboratory investigations, as supported by your medical records.

Doctor is a person who is: Legally qualified to practice medicine, licensed as a doctor by the state where treatment is received, and Licensed to treat the type of condition for which a claim is made.

A doctor does not include you or any of your family members.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family: Son, Daughter, Mother, Father, Sister, Brother.

This includes step-family members and family-members-in-law.

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack (Myocardial Infarction) does not include: Any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following: New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions: A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into complete remission because of primary treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases: Bronchiectasis, Cardiomyopathy Cirrhosis Chronic obstructive pulmonary disease, Congenital Heart Disease, Coronary Artery Disease, Cystic fibrosis, Hepatitis Interstitial lung disease, Lymphangioleiomyomatosis, Polycystic liver disease, Pulmonary fibrosis, Pulmonary hypertension, Sarcoidosis Valvular heart disease.

A Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Party to a Civil Union: In Illinois, a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Pathologist is a doctor who is licensed: To practice medicine, and By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either: Ischemic:

Due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or Hemorrhagic: Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include: Transient Ischemic Attacks (TIAs) Head injury Chronic cerebrovascular insufficiency Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging.

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing: Computed Axial Tomography (CAT scan) images, or Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are: Not working at any job for pay or benefits, Under the care of a doctor for the treatment of a covered critical illness, and Unable to Work, which means either: During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking

prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must: Be a full-thickness or third-degree burn, as determined by a doctor. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock. Cause cosmetic disfigurement to the body's surface area of at least 35 square inches. Be caused solely by or be solely attributed to a covered accident.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of: Spontaneous eye movements, Response to painful stimuli, and Vocalization.

Coma does not include a medically-induced coma. To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident. To be

considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases: Brain Aneurysm, Diabetes Encephalitis, Epilepsy, Hyperglycemia, Hypoglycemia, Meningitis.

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases: Amyotrophic lateral sclerosis, Cerebral palsy, Parkinson's disease, Poliomyelitis.

The diagnosis of paralysis must be supported by neurological evidence.

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases: Retinal disease, Optic nerve disease, Hypoxia.

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a

covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases: Alzheimer's disease , Arteriovenous malformation.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device.

To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases: Alport syndrome, Autoimmune inner ear disease, Chicken pox, Diabetes, Goldenhar syndrome, Meniere's disease, Meningitis, Mumps.

PROGRESSIVE DISEASES RIDER

All limitations and exclusions that apply to the critical illness plan also apply to the rider unless amended by the rider. Date of Diagnosis is defined for each specified critical illness as follows: Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease): The date a Doctor Diagnoses an Insured as having ALS and where such Diagnosis is supported by medical records. Sustained Multiple Sclerosis: The date a Doctor Diagnoses an Insured as having Multiple Sclerosis and where such Diagnosis is supported by medical records.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or

both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days: Muscular weakness, Loss of coordination, Speech disturbances, or Visual disturbances.

OPTIONAL BENEFITS RIDER

All limitations and exclusions that apply to the critical illness plan also apply to the rider unless amended by the rider.

Date of Diagnosis is defined as follows: Advanced Alzheimer's Disease: The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease. Advanced Parkinson's Disease: The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease. Benign Brain Tumor: The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Optional Benefit is one of the illnesses defined below and shown in the rider schedule:

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease.

To be incapacitated due to Alzheimer's Disease, the insured must: Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the insured to be incapacitated. Parkinson's Disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the insured must: Exhibit at least two of the following clinical manifestations: Muscle rigidity,

Tremor, Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses), and Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain.

The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome. Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor. Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue. Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan,

ADLs include the following: Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment; Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs; Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment; Transferring –the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment; Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment; Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

ACCIDENT LIMITATION AND EXCLUSIONS INITIAL ACCIDENT EXCLUSIONS

EXCLUSIONS

Plan exclusions apply to all riders unless otherwise noted.

We will not pay benefits for accidental injury, disability or death contributed to, caused by, or resulting from*:

War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion

or civil state of belligerence. War does not include acts of terrorism. Suicide – committing or attempting to commit suicide, while sane or insane. Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for: Allergic reactions; Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid or other arthropod bites or stings. In Illinois: any bacterial infection, except an infection which results from an accidental injury or an infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance; any viral or microorganism infection or infestation; or any condition resulting from insect, arachnid or other arthropod bites or stings. In North Carolina: any viral or microorganism infestation or any condition resulting from insect, arachnid or other arthropod bites or stings; An error, mishap or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness; Any related medical/surgical treatment or diagnostic procedures for such illness. Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally. Racing – riding in or driving any motor-driven vehicle in a race, stunt

show or speed test in a professional or semi-professional capacity. Illegal Occupation – voluntarily participating in, committing or attempting to commit a felony or illegal act or activity, or voluntarily working at or being engaged in, an illegal occupation or job. Sports – participating in any organized sport in a professional or semi-professional capacity for pay or profit. Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident. Felony (In Idaho only) – participation in a felony. For 24-Hour Coverage, the following exclusions will not apply: An injury arising from any employment. An injury or sickness covered by worker's compensation.

DEFINITIONS

Accidental Injury means accidental bodily damage to an insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. A Covered Accidental Injury is an accidental injury that occurs while coverage is in force. A Covered Accident is an accident that occurs on or after an insured's effective date while coverage is in force, and that is not specifically excluded by the plan.

Ambulatory Surgical Center is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post- surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

Dependent Child or Dependent Children means your or your spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26 (and in Louisiana, unmarried).

Newborn children may be automatically covered from the moment of birth for 60 days. Newly adopted children (and foster children in North Carolina and Florida) may also be automatically covered for 60 days. See certificate for details.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or is a duly qualified medical practitioner according to the laws and regulations in the state in which treatment is made.

A Doctor does not include the insured or an insured's family member. In South Dakota however, a doctor who is an employee's family member may treat the insured if that doctor is the only doctor in the area and acts within the scope of his practice. For the purposes of this definition, family member includes the employee's spouse as well as the following members of the employee's immediate family son, daughter, mother, father, sister, and brother. This includes step-family members and family-members-in-law.

The term Hospital specifically excludes any facility not meeting the definition of hospital as defined in this plan, including but not limited to: A nursing home, An extended-care facility, A skilled nursing facility, A rest home or home for the aged, A rehabilitation facility, A facility for the treatment of alcoholism or drug addiction, or An assisted living facility.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Telemedicine Service means a medical inquiry with a doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include telemedicine services.

Urgent Care is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

Hospital Intensive Care Unit means a place that meets all of the following criteria: Is a specifically designated area of the hospital called a hospital intensive care unit; Provides the highest level of medical care; Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; Is separate and apart from the surgical recovery room and from rooms, beds and wards

customarily used for patient confinement; Is permanently equipped with special life-saving equipment for the care of the critically ill or injured; Is under close observation by a specially trained nursing staff assigned exclusively to the hospital intensive care unit 24 hours a day; and Has a doctor assigned to the hospital intensive care unit on a full-time basis.

The term Hospital Intensive Care Unit specifically excludes any type of facility not meeting the definition of hospital intensive care unit as defined in this plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units and the following step-down units: A progressive care unit; A sub-acute intensive care unit; or An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following: A progressive care unit; A sub-acute intensive care unit; An intermediate care unit; or A pre- or post-intensive care unit. An intermediate intensive care step-down unit is not a hospital intensive care unit as defined in this plan.

Psychiatrist is a doctor of medicine who specializes in the diagnosis and treatment of mental disorders.

Psychologist is a clinical, mental health professional who works with patients. A psychologist is not a Doctor of Medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine.

Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the treatment of alcoholism or drug addiction.

CATASTROPHIC ACCIDENT EXCLUSIONS

We will pay the Catastrophic Accident Benefit once per lifetime for each insured covered under the rider.

Please refer to the the Initial Accident Treatment insert for other exclusions applicable to this coverage.

DEFINITIONS

Catastrophic Accident Elimination Period is the period of days after the date of a Covered Accident for which no benefits are payable under this rider.

Catastrophic Loss refers to an injury from a covered accident that causes total and irrecoverable: Loss of both hands or both feet; or Loss or loss of use of both arms or both legs; or Loss of one hand and one foot; or Loss of use of one arm and one leg; or Loss of sight of both eyes; or Loss of hearing in both ears; or Loss of the ability to speak.

Note: The loss of use of an arm means the functional loss of the entire arm from the shoulder to the hand. The loss of use of a leg means the functional loss of the entire leg from the hip to the foot. The loss of sight means both eyes are totally blind and that no sight can be restored. The loss of hearing means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device. The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

Your coverage may be continued with certain stipulations. See certificate for details.

DISABILITY LIMITATIONS AND EXCLUSIONS

If this coverage will replace any existing individual policy please be aware that it may be in your best interest to maintain their individual guaranteed-renewable policy.

We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

We will not pay benefits for a Disability that is caused by or occurs as a result of: 1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot; 2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National

Guard or Reserve; 3. An intentionally self-inflicted Injury; 4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated; 5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft; 6. Mental Illness as defined;

7. Alcoholism or drug addiction; 8. An Injury that arises from any employment; 9. Injury or Sickness that is covered by Worker's Compensation.

PREGNANCY LIMITATION

Within the first nine months of the Effective Date of coverage, we will not pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for nine months from the Effective Date of coverage, Disability benefits for childbirth will be payable. The maximum Period of Disability allowed for Disability due to childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.

TERMS YOU NEED TO KNOW

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Benefit Period is the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any period of disability. Each new Benefit Period is subject to a new Elimination Period.

Complications of Pregnancy refers to:

Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication.

Examples of such Complications of Pregnancy are: 1. Acute nephritis; 2. Nephrosis; 3. Cardiac decompensation; 4. Missed abortion; 5. Disease of the vascular, hemopoietic, nervous, or endocrine systems; and 6. Similar medical and surgical conditions of comparable severity.

Further Complications of Pregnancy include:

1. Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement; 2. Ectopic pregnancy that is terminated; and 3. Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include the following conditions:

1. Multiple gestation pregnancy; 2. false labor; 3. occasional spotting; and 4. morning sickness.

Other similar conditions associated with the management of a difficult pregnancy are not considered Complications of Pregnancy. Cesarean deliveries are not considered Complications of Pregnancy.

Effective Date is the date shown on the Certificate Schedule, provided you are actively at work, or if not, it is the date you are actively at work as an eligible employee

Elimination Period is the number of continuous days at the beginning of your Period of Disability for which no benefits are payable. Each new Benefit Period is subject to a new Elimination Period.

Injury refers to a bodily injury not otherwise excluded that is directly caused by a covered accident, is not caused by Sickness, disease, bodily infirmity, or any other cause, and occurs while coverage is in force.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illnesses and Emotional Disorders includes but are not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders or other condition usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Partial Disability refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full- Time Job. To qualify as Partial Disability, you are able to work at any job earning less than 80 percent of the Annual Income of your Full-Time Job at the time you became disabled.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition that is not caused by an Injury, first manifested and first treated after the Effective Date of coverage and occurs while coverage is in force.

Termination Coverage will terminate on the earliest of: (1) the date the master policy is terminated, (2) the 31st day after the premium due date if the required premium has not been paid, (3) the date you cease to meet the definition of an employee as defined in the master policy, (4) the date you no longer belong to an eligible class, (5) age 75.

Total Disability refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full- Time Job. To qualify as Total Disability, you may not be working at any job.

You and Your refers to an employee as defined in the Plan

Aflac cannot guarantee that guaranteed issues rates will be available past the first year of enrollment
All policy cancellations must go through Bill Loeweth at BILLLOWETH@WBPINSURE.COM

SPD

Life and Accident Insurance Program

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

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

Section 1. Life and Accident Benefits

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

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

Section 2. Beneficiary Designations

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

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

Section 3. Claims and Appeals Procedures

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

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

Time Frames and procedures for Appealing the Initial Determination

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

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

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

SCHEDULE OF BENEFITS FOR LIFE INSURANCE AND PERSONAL ACCIDENT INSURANCE ("PAI")

Company-Paid Basic Life Insurance Coverage - Employee

Waiting Period None

Contributions Company pays the entire cost for basic life insurance coverage. No employee contributions are required.

Coverage Amount 1 times base annual salary (monthly rate of pay times 12), rounded to next higher $1,000

Maximum Benefit $500,000

Minimum Benefit $10,000

When Coverage Ends

Your coverage ends on the earliest of the following: • the date the group policy ends; or • the date you no longer meet the eligibility requirements; or • the date the group policy is amended so you are no longer eligible; or • 31 days (the grace period) after the due date of any premium contribution which is not paid; or • the last day for which premium contributions have been paid following your written request to cease participation under the group policy.

Guaranteed Issue Level

All coverage guaranteed.

Accelerated Benefit Option ("ABO") – special election for lump sum advance payment for terminal illness

Eligibility:

Eligible active and disabled employees Life Expectancy: 24 months or less Minimum: 25% of your company paid life insurance Maximum: 100% of your company paid life insurance Frequency: Payable only once during employee's lifetime Other Restrictions and Considerations: The ABO is subject to state availability and regulation, including limitations on the amount that may be paid under the ABO feature. The amount of the Company life insurance benefit payable as a death benefit is reduced by the amount paid under the ABO feature. The ABO distribution may be taxable. You should consult with your tax advisor before receiving an ABO distribution.

Continuation of Coverage During Disability

If you become totally disabled, your life insurance coverage may be continued. Contact the UABC for additional information

Continuation of Coverage During Leave of Absence

If your active employment ends due to a personal, educational or military leave, you may continue Company life insurance benefit coverage for a specified period as long as you pay 100% of the required premiums. You will be billed directly by the UABC. If your leave continues beyond the specified period, you may convert your coverage to an individual policy if you wish to retain your coverage. Contact the UABC for additional information.

Conversion to Individual Policy

You may convert all or part of your Company life insurance benefit coverage to an individual policy within 45 days after your group coverage: • ends because you no longer work for the Company, or • ends after your specified leave of absence coverage period (provided you continued the coverage by making the required premium payments directly to the insurance company). Notice of the conversion right will be presented to you

or sent to your last known address. Receipt of this certificate will constitute such notice. Nothing contained herein will be construed to continue any insurance beyond the period provided in this certificate. If you die within the 31-day period after group coverage ends and meet the conversion eligibility requirements, the insurance company will pay a death benefit regardless of whether a conversion application has been made; if you die after 31 days from the date group coverage ends and have not elected conversion, no benefit is payable. Additional restrictions may apply to your conversion rights. Please contact the UABC for additional information.

Company-Paid Life Insurance Coverage – Dependent

Company-paid life insurance coverage for dependents is not provided to your employee group. See the Employee-Paid Optional Life Insurance Coverage summary below for information regarding your dependent life insurance coverage options.

Employee-Paid Voluntary Life Insurance Coverage – Employee and Eligible Dependents

Eligibility If you reduce or cancel the automatic coverage described below and wish to enroll yourself at a later date, you will be required to submit evidence of good health.

Type of Coverage Group Term Life Grandfathered GUL Coverage:

Certain eligible employees may have Group Universal Life ("GUL") insurance that is "grandfathered" under the Plan. Unlike group term life coverage, GUL coverage allows you to choose to pay only for the cost of the life insurance protection or you can build cash value by also making premium contributions above the cost of the insurance. If you have grandfathered GUL coverage under the Plan, please contact the insurance company shown in the Contact Information Sheet if you have any questions.

Waiting Period None

Contributions

You make employee contributions by payroll deductions for the full cost of coverage. You may call the UABC to obtain the costs of the required premiums. The premiums are subject to change.

Optional Coverage Amounts

That May Be Elected Employee: 1 to 10 times base annual salary, rounded to next higher $1,000 Eligible Spouse/Qualified Domestic Partner: $10,000 increments Dependent Child: $10,000

New Hire Automatic Enrollment

Employee: Automatically enrolled in optional life insurance coverage equal to four times your base annual salary (not to exceed $800,000) Eligible Spouse/ Qualified Domestic Partner: No automatic enrollment Dependent Child: No automatic enrollment You may cancel or reduce the amount of your automatic coverage within 45 days by sending written notice to the insurance company identified in the Contact Information Sheet. Please contact the insurance company for additional information.

Maximum Benefit Employee:

$3,000,000 (in combination with the Company-Paid Basic Life Insurance Coverage) Eligible Spouse/Qualified Domestic Partner: $250,000 Dependent Child: $10,000

Minimum Benefit Employee: 1 times base annual salary, rounded to next higher $1,000 Eligible Spouse /Qualified Domestic Partner: $10,000 Dependent Child: $10,000

Automatic Increase Feature

Your coverage will automatically increase (not to exceed the plan maximum) if your salary increases. If your coverage increases, your payroll deduction amount will also increase to cover the additional life insurance protection. If your salary decreases, your coverage will decrease as well.

When Coverage Ends

Your coverage ends on the earliest of the following: • the date the group policy ends; or • the date you no longer meet the eligibility requirements; or • the date the group policy is amended so you are no longer eligible; or • 31 days (the grace period) after the due date of any premium contribution which is not paid; or • the last day for which premium contributions have been paid following your written request to cease participation under the group policy. An insured dependent's coverage ends on the earliest of the following: • the date the dependent no longer meets the eligibility requirements; or • 31 days (the grace period) after the due date of any premium contribution which is not paid; or • the last day for which premium contributions have been made following your written request that insurance on your eligible dependents be terminated; or • the date you are no longer covered under the group policy; or • the date the Dependents Supplement terminates.

New Hire - Guaranteed Issue Level

Employee: 4 times base annual earnings up to $800,000 Eligible Spouse/Qualified Domestic Partner: $30,000 Dependent Child: $10,000

Annual Enrollment - Guaranteed Issue Level

Employee life insurance may be increased by one times annual salary provided the resulting total amount of insurance does not exceed the lesser of 4 times annual salary or $800,000. Spouse life insurance may be increased by one $10,000 increment, provided the resulting total amount of insurance does not exceed $30,000. Child life insurance may be elected. Any increase to a higher level than what is stated above will require evidence of good health.

"Life Event" (See below) – Guaranteed Issue Level

Employee life insurance may be increased by one times annual salary provided the total resulting amount of insurance does not exceed the lesser of 4 times annual salary or $800,000. Spouse life insurance may be increased by one $10,000 increment, provided the resulting total amount of insurance does not exceed $30,000. Child life insurance may be elected. Any increase to a higher level than what is stated above will require evidence of good health.

Life Event Option

When a "Life Event" occurs, you may enroll for or increase coverage without providing evidence of good health, provided the additional coverage is requested within 45 days following a qualified "Life Event." "Life Event" changes are: • Birth or adoption or otherwise acquiring a newly eligible child • Death of a dependent (spouse/Qualified Domestic Partner or child) • Divorce, legal separation or annulment • Dissolution of a qualified domestic partnership • Marriage or creation of qualified domestic partnership • Purchase of a primary home

Late Enrollment No guaranteed coverage; evidence of insurability is required.

Accelerated Benefit Option ("ABO")

Eligibility: Eligible active, disabled, and retired employees, insured spouses/qualified domestic partner, and children Life Expectancy: 24 months or less Minimum: Employee 25% of optional life insurance; Spouse/QDP $10,000; Child $10,000 Maximum: 100% of the amount of optional, Spouse/QDP or Child life insurance Frequency: Payable only once during insured's lifetime

Other Restrictions and Considerations:

The ABO is subject to state availability and regulation, including limitations on the amount that may be paid under the ABO feature. The amount of the life insurance benefit payable as a death benefit is reduced by the amount paid under the ABO feature. The ABO distribution may be taxable. You should consult with your tax advisor before receiving an ABO distribution.

Waiver of Premium

If you become totally disabled, your life insurance premiums may be waived. Contact the UABC for additional information.

Portability of Life Insurance Coverage

Yes, the insured may continue his or her coverage by paying the applicable insurance premiums directly to the insurance company. These insurance rates will be higher than the employee group rates. Please contact the UABC for additional information.

Continuation of Coverage During Disability

If you are on an approved disability your optional life insurance benefit will remain in effect for six months from your date of disability as long as you continue to pay the appropriate premium. You will be billed directly by the UABC for the premium. Contact the UABC for additional information.

Continuation of Coverage During Unpaid Leave of Absence

If you are on a Company-approved unpaid leave of absence, your optional life insurance benefit will remain in effect as long as you continue to pay the appropriate premium. You will be billed directly by the UABC for the premium. If your leave continues beyond the specified period, you may port or convert your coverage if you wish to retain your coverage. Contact the UABC for additional information.

Conversion to Individual Policy

You may convert all or part of your Company life insurance benefit coverage to an individual policy within 45 days after your group coverage: • ends because you no longer work for the Company, or • ends after your specified leave of absence coverage period (provided you continued the coverage by making the required premium payments directly to the insurance company). Notice of the conversion right will be presented to you or sent to your last known address. Receipt of this certificate will constitute such notice. Nothing contained herein will be construed to continue any insurance beyond the period provided in this certificate. If you die within the 31-day period after group coverage ends and meet the conversion eligibility requirements, the insurance company will pay a death benefit regardless of whether a conversion application has been made; if you die after 31 days from the date group coverage ends and have not elected conversion, no benefit is payable. Additional restrictions may apply to your conversion rights. Please contact the UABC for additional information.

Additional Limitations and Exclusions

The death benefit, or an increase in the death benefit, will be limited to a refund of premiums paid if the insured commits suicide or dies due to intentionally self-inflicted injuries within the first two years of the effective date of the optional life insurance coverage or within two years of the effective date of a requested increase in coverage. Please contact the insurance company identified in the Contact Information Sheet for additional information regarding any additional limitations and exclusions.

Personal Accident Insurance ("PAI") Benefits

Company-Paid PAI

This benefit provides a benefit if you suffer an accidental dismemberment (the loss of a limb or your eyesight) or you die as a direct result of a non-work-related accident. The benefit is provided under a contract with the insurance company identified in the Contact Information Sheet. Contributions: The Company pays the entire cost for PAI insurance coverage. No employee contributions are required. Benefit Amounts: $4,000 benefit for accidental death; lower benefit amounts for accidental dismemberments depending on the type of covered loss.

Voluntary PAI

This benefit pays benefits for certain accidental death, dismemberment and paralysis and injuries that happen either on or off the job. Participation in this coverage is completely voluntary. The benefit is provided under a group insurance contract with the insurance company identified in the Contact Information Sheet. Eligibility: You must enroll to receive voluntary PAI coverage. If you do not enroll within 45 days following your date of employment as an eligible employee, you may enroll only during the annual enrollment period or when you have a "change in status event," as described in the General Plan Information chapter, which permits you to enroll mid-year. Contributions: You make employee contributions by payroll deductions for the full cost of coverage. You may call the UABC to obtain the costs of the required premiums. The premiums are subject to change. Voluntary coverage amounts that can be elected: Employee: $25,000 to $500,000, in $25,000 increments Eligible Spouse / Qualified Domestic Partner: $10,000 to $500,000,in $10,000 increments Dependent Child: $10,000 to $100,000, in $10,000 increments Benefit amounts depend on the type of accidental injury and whether it results in death or a covered loss. Conversion: If Voluntary PAI coverage ends because you or your dependent are no longer eligible for coverage or if you leave your job (prior to age 80) for any reason, you may convert your coverage to an individual accidental death and dismemberment policy, subject to plan provisions. Application must be made and the required premium paid within 31 days after the coverage ends. Evidence of insurability is not required. The initial premium for the individual policy will be based on the insured person's attained age, risk class, and amount of insurance provided, at the time of application.

Additional Detailed Information Is Available

Additional detailed information on the benefits provided under the Life and Accident Insurance Program described in this SPD is available by contacting the insurance company and/or by consulting the Plan Website. Consult the Contact Information sheet at the back of this SPD (or the updated sheet if one has been provided to you) for information on how to contact the insurance company and/or to access the Plan Website.

Medicare

Medicare will become your primary health insurance when you reach age 65. You must sign up for Medicare three months before your 65th birthday to maximize your benefit and minimize your costs. Sign up at the Social Security website, *www.socialsecurity.gov*. The Medicare website *ww.medicare.gov* is a good source of information regarding Medicare

Part A: Free - pays a portion of hospital costs (Co pay for services).

Part B: Monthly Premium based on MAGI - pays a portion of the doctor bills, outpatient services and medical supplies.

Medicare HMOs – You pay part B premium, plus possible additional premiums.

Part C: Covers all the services that original Medicare Plans cover except hospice care, and may cover other services, (dental, and health wellness).

Part D: Covers prescription drug plans.

1-800-MEDICARE (800-633-4227) www.medicare.gov

Teamster Privilege Program https://teamster.org/benefits/teamster-privilege Offers Medicare Supplemental insurance and Medicare Part D prescription drug program.

Teamsters Member Assistance Program (TMAP)

What Is the Teamsters' Member Assistance Program (MAP)?

The Teamsters Union offers a free confidential program designed to help members and their families identify and resolve personal problems or concerns. Our trained MAP peer coordinators are union members helping union members.

We All Have Ups and Downs *It's not always easy deciding when to ask for help.*

Your MAP Coordinator will respectfully listen to your problem and will assist you in developing a plan of action that will meet your needs. If necessary, you will be referred to a qualified service provider in your community. The MAP Coordinator will also follow up with you to ensure that you are getting the help you need and that you are satisfied with the referral

How Do You Know If You Really Do Have A Problem? *Ask yourself these questions:*

- Do I think about a problem frequently, or am I always worried about the same thing?
- Am I telling myself the problem "isn't that bad and will just go away," although it doesn't?
- Do I feel tired, depressed, frustrated, angry or sick?
- Is my job performance or dependability being affected?
- Do I feel like giving up?

What Kind of Problems Can The Member Assistance Program Help With?

- Depression/Anxiety
- Debt Management
- Grief and Loss
- Alcohol/Drug Dependency
- Gambling
- Relationship Problems

- Divorce
- Child/Teen Conduct
- Domestic Violence
- Elder Care
- Trauma Reactions

Is the Union's MAP Really Confidential?

Yes, the program is highly confidential! We will not discuss your problem with anyone without your written consent.

The only limits by law are the intent to harm yourself or others, and child or elder abuse.

What Will It Cost?

The services of the MAP are free. Your MAP representative will work with you to make effective use of your health insurance benefits and community resources

What Is The Next Step?

To get started, call or visit a Teamsters MAP Representative to begin the process. The Member Assistance Program is voluntary, so you need to take the first step. A MAP Representative can help you determine whether you need to take action. Remember, it's better to deal with the problem before it becomes overwhelming

CALEB GOOD
Chairman
Eastern Region Coordinator
ATL BOS CHS CLE EWR FLL
IAD LGA MCO ORD PHL TPA
(630) 485-0227 Cell

MIKE BROOKS
Central Region Coordinator
DEN
PHX (303) 335-6540 Cell

STEVE LOONE
Western Region Coordinator
GUM HNL LAS LAX KOA LIH
OGG PDX SAN SEA SFO SNA
(650) 745-5864 Cell

STEVE CRUMMEY
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DOMINIC FIERO
IAH HOU AUS DFW MSY SAT
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Technicians Agreement Article 10 Leaves of Absence

A. An employee who is unable to report for work for any reason must notify the Company in advance, whenever possible. The Company shall establish a designated absentee number for employees to use for contacting the Company when they are unable to report to work. An employee who does not have prior written permission may not be absent except for sickness, injury or other causes beyond the employee's control.

B. An employee who must be absent, and who has not received prior written permission, must notify the Company or its designated representative at the designated absentee number before the starting time of the employee's shift on the first day and must give the reason for the employee's inability to report for work. Unless excused by the Company or its designee, the employee is required to notify the Company or its designee of the employee's absence with explanation each day the employee is absent. Proper notification occurs when the Company or its designee has been contacted at the designated absentee number by the employee and given the reason why the employee is unable to report for work.

C. An employee is subject to discharge if absent from work two (2) consecutive days without notifying the Company of the reason for his inability to report to work, absent extenuating circumstances. Notification occurs when an employee notifies the Company or its designee at the designated absentee number.

Return to Work

1. An employee on an authorized leave of absence of over thirty (30) days, must notify the employee's supervisor in writing at least ten (10) days in advance of the employee's expected return.

2. An employee returning from Family and Medical Leave shall return to the Bid Area, shift, and regular days off vacated. Except as otherwise provided herein, an employee returning from other leaves shall return to the position he vacated (i.e., return to shift, days off, Bid Area and classification) prior to such leave. If the position is no longer available he may choose to fill any other open position in his Bid Area. If there are no open positions in the employee's Bid Area he may exercise his seniority to displace the junior employee in his Bid Area, station/point or system if necessary.

3. The Company has the right to verify the fitness of an employee to return to work after any absence by having the employee examined by a Company approved physician.

E. Authorized Leaves and Associated Benefits

1. Personal Convenience

Employees may request short term leaves of up to eighty (80) hours off for personal convenience reasons subject to the needs of the service. Such requests will be approved no later than twenty-four (24) hours prior to the time off requested. An employee may request such personal convenience time off at any time during the calendar year without regard to his remaining unused vacation time. Further, if an employee would have been approved for a VAC-DAT he will not be denied a Personal Convenience Day. If the Personal Convenience time is approved by the supervisor, such time will not be counted as an absence for disciplinary purposes.

2. Extended Illness Status (EIS)

a. Upon written application, accompanied by proper written certification from an employee's doctor confirming the need, employees who are not eligible for Transitional Duty and who have exhausted or elected not to use sick or OJI accruals will be granted leaves of absence for illnesses, injuries, or pregnancies that prevent them from working. Leaves may not exceed one hundred and twenty (120) days, but are renewable for

one hundred and twenty (120) day periods, upon reapplication and re-certification until the employee is able to return to work, to a maximum of the shortest of the period of incapacity, five (5) years, or a period equal to the employee's length of employment. Once the employee is released without restrictions by his Doctor to perform his normal job functions, he shall be returned to his vacated position. If such position has been filled, he may exercise his seniority. Proof of illness or disability may be required through physician certification.

b. Seniority continues to accrue while on approved EIS.

c. Vacation/Holiday – While on EIS employees do not accrue vacation, sick leave, holidays, etc., except that an employee who is off work due to an occupational illness or injury will continue to accrue vacation credit.

3. Emergency Leave of Absence (ELA)

a. In the event of death or the life-threatening illness of a member of an employee's immediate family, the employee will receive up to forty (40) hours off at straight time pay, depending upon the employee's needs. For the purposes of this policy, the immediate family includes: i. The employee's: spouse, children, step children, parents, step parents, sister, brother, grand-parents, grandchildren, domestic partners where required by law, Parents of the employee's spouse, and Dependents living in the employee's household.

b. While no more than two (2) instances or a total of eighty (80) hours of ELA time will be paid per individual family member for the period of employment, additional time off without pay will be made available to employees covered by the Family and Medical Leave Act for a qualifying family member with a serious health condition, if requested. Otherwise, such additional time off without pay is within the discretion of an employee's supervisor.

c. Where extenuating circumstances exist, a Supervisor may approve more than two (2) instances but in no event shall paid time exceed (80) hours for each covered immediate family member.

d. ELA time is not charged against an employee's sick bank, nor counted as an absence for disciplinary purposes. ELA time does not disqualify an employee from the Attendance Recognition Program.

e. The Company will provide positive space on-line passes for travel to attend the funeral/memorial service and to return from downline locations. The Company will also assist in other travel arrangements as needed.

f. A reasonable amount of unpaid time off will be allowed in the case of the death or life-threatening illness of an employee's spouse's grandparents.

4. Company Offered Leaves of Absence (COLA)

a. Nothing herein shall prevent the Company from offering leaves of absence (COLA's) to Technicians and Flight Simulator Technicians. COLAs will be posted for bid whenever a furlough situation exists. The duration of the leave will be included in the posting. COLAs may not be taken by employees who are being furloughed. They will be granted in bid seniority order. In the event of a station/base closure, this paragraph will not be applicable.

b. Outside employment will be allowed during a COLA. The employee must notify the employee's supervisor or his designee in writing of any outside employment. If the question of potential conflict arises, the final decision will be made by the senior corporate officer in the Human Resources Department.

c. If an employee is due to be furloughed during a COLA, the employee's status will be changed from COLA to furlough. Written notice will be given to the employee. d. An employee granted a COLA will have a

guaranteed right of return to the position vacated at the end of the COLA. An employee will not be required to return to work during the COLA period except by mutual agreement.

e. Sick and Occupational Injury banks and vacation time will be retained but will not accrue during COLAs. f On-line pass privileges will be available to the employee and eligible family members for the entire COLA period. A letter authorizing travel will be issued to the employee.

g. The Company and the Union will meet and confer to discuss benefit coverage continuation during any proposed COLA.

h. Seniority-See Article 4 of this Agreement.

5. Personal Leave of Absence (PLA)

a. Eligibility – The employee must have been continuously employed for six (6) months.

b. Length – Personal leaves of absence will be issued for up to a six (6) month period. Extensions will not be approved if they result in total personal leave exceeding twelve (12) months or the employee's length of active service, whichever is shorter. An employee may apply to return to a position at any time during the leave. At the end of a leave which is longer than ninety (90) days the employee may only return to an available position. If no such position is available he will be placed on recall in Furlough and Recall Date (FRD) Craft Seniority order.

c. Outside employment – An employee on personal leave of absence may not accept employment or receive pay for services from any other organization in competition with the company.

d. Application for Leave – A written application must be made to the employee's supervisor. It must state the reason for and the length of the leave requested.

e. Seniority – See, Article 4 of this Agreement.

f. Sick Pay/Occupational Injury Pay - All sick/occupational injury pay accruals are retained but cease to accrue during the leave.

g. Vacation Credit

i. With supervisor approval, the employee may choose to be paid for all remaining earned vacation from the prior year in either of the following ways:

a) A lump payment may be paid at the time the leave begins,

or

b) The employee may defer vacation payment until vacation is used when the employee returns.

ii. If an employee's leave carries into the next calendar year, remaining unused earned vacation will be paid before December

iii. Vacation credit will not accrue during the period of leave.

6. Educational Leaves of Absence

Employees may be granted an educational leave of absence if they are enrolled full-time in an accredited academic or vocational institution. The administrative and benefits provisions of Personal Leaves will apply with the following exceptions:

a. Duration of Leave – Duration of educational leaves should be in direct relationship to the length of the academic term (such as a quarter or semester) but in no case can the leave be longer than the employee's length of service.

b. Expiration of Leave – An educational leave will expire thirty (30) days after the last approved academic term ends unless extended by the Department Head.

c. Employment While on Leave – With the prior written approval of their Department Heads and Human Resources, employees may work while enrolled as students.

d. Proof of Enrollment – Employees must submit proof of enrollment and attendance before they return to work from their educational leave.

7. Birth of a Child

Any non-probationary employee who has not been granted maternity leave in conjunction with a birth may request an unpaid parental leave within twelve (12) months after the birth or adoption of his/her child. A request for parental leave must be submitted in writing and include the requested dates. The leave request may not exceed ninety (90) days. The Company will not deny the parental leave, however the granting of any extensions beyond the initial ninety (90) days shall be entirely at the Company's discretion.

8. Benefits for Personal Convenience, Extended Illness Leave, Emergency, Personal, and Educational and Birth of a Child Leaves of Absence

a. Medical/Dental/Vision – Unless otherwise specified by this Agreement, the terms of the plan or required by law, current medical, dental and vision coverage shall be continued through the end of the month in which the LOA begins, on the same terms and conditions as apply to an active employee. Such coverage may be continued thereafter at the technician's **employee's** expense at the same rate as the COBRA rate for the duration of the LOA subject to plan changes and availability. In the event of termination of employment while on LOA, such coverage may be continued at the employee's expense using COBRA eligibility at the COBRA rate for the COBRA period provided by law (currently eighteen (18) months) following the last day of the month in which termination of employment occurred, subject to plan changes and availability. The foregoing shall not apply with respect to EIS, which shall instead be governed by Article 16.E and the following requirements. Once an employee commences EIS, a five (5) year period shall commence during which the maximum period of subsidized coverage shall be twenty-four (24) months as specified in Article 16.E. If the employee returns to active service prior to expiration of the twenty-four (24) month period and subsequently goes on EIS prior to the expiration of the five (5) year period, the employee shall be eligible for the balance of the twenty-four (24) months specified in Article 16.E. At the end of the five (5) year period, the twenty-four (24) months of subsidized coverage shall again be available if the employee subsequently goes out on EIS.

b. Life and Accident Insurance – If on a paid status, current life and accident insurance coverage is unaffected. Unless otherwise specified by the terms of the plan or required by law, if on an unpaid status, the employees continue all or a portion of their current life and accident insurance coverage if so allowed by the individual life insurance company provider. The Company shall provide written notice regarding the employee's continuation responsibility and contact information for the life insurance provider at the time the employee commences an unpaid status. Continuation will be at the employee's expense and must be arranged by the employee directly with the individual insurance company. The premiums for life and accident insurance continuation will be based on conversion rates.

c. Retirement – Unless otherwise required by law, vesting, eligibility and benefit accrual service credit in the Continental Airlines Retirement Plan (CARP) shall be governed by the terms of CARP.

d. Passes – Based on Company Pass Policy and upon request and with the approval of their Department Head, technicians and their eligible family members on a leave of absence may use on-line travel privileges at their active employee pass classification. In the same manner, any buddy and vacation passes in their possession at the time the leave begins may be used as well. Employees who are on Personal and Education Leaves of Absence are not eligible for pass travel.

9. Jury Duty

a. The Company recognizes jury duty as a civic responsibility and will release employees for jury duty. Employees will not suffer any loss of pay for jury duty, allowing a reasonable amount of time for the employee to travel to/from his home for jury duty, if necessary. Further, employees will be pay protected (to extend to the end of the employee's following work week) for any trade days and/or shifts they were scheduled to work while on jury duty provided the trade days were scheduled prior to the employee's jury duty notification. Employees may retain payment received for jury service. An employee who gets a jury summons must submit a copy of it to the employee's supervisor.

b. An employee on jury duty for three (3) days or more will be scheduled to work a day shift with Saturdays and Sundays off during jury service. If the employee is temporarily released from jury service for a calendar week or more, the employee's regular shift will be reinstated with Saturday and Sunday off. This provision shall not prevent local stations from establishing rules and guidelines that best satisfy their individual needs. c. When jury duty is completed, the employee must furnish his supervisor with a court-validated statement of attendance indicating the dates he served on jury duty.

10. Witness Service

a. An employee who appears as a witness in a legal proceeding at the request of the Company will be paid during witness service. Procedures will be the same as those for jury duty.

b. An employee who serves as a witness in other legal proceedings will not be paid, unless he is compelled by subpoena to testify in such proceedings.

11. Family and Medical Leave (FML)

a. Employees may take up to ninety (90) days of leave during any rolling twelve (12) month period. A rolling twelve (12) month period is determined by counting backwards twelve (12) full months from the first day of any FML. FML may be used for the birth or adoption of a child; placement of a child in foster care, to care for a minor child (son or daughter, including biological, adopted, foster, or stepchild, for whom the employee is a primary care giver, or such person over age eighteen (18) if that person is incapable of self-care due to a verified physical or mental disability), spouse or parent (including a biological parent or a person who raised the employee as a child); with a serious health condition; or for their own serious health condition which makes them unable to perform their job.

b. FML shall be determined pursuant to the technician's submission of an approved and acceptable medical certification.

c. Benefits

i. Medical/Dental/Vision – Current medical, dental and vision coverage may be continued for the duration of the FML, on the same terms and conditions as apply to an active technician. A technician who terminates employment while on FML may continue current medical, dental and vision coverage at the technician's expense using COBRA eligibility at the COBRA rate for the COBRA period (currently eighteen (18) months) following the last day of the month in which the termination of employment occurred, subject to plan changes and availability. For any period of Family and Medical Leave which is taken as unpaid leave, an employee must elect and submit a monthly payment for health care continuation within thirty-one (31) days of the Benefits Department notice of Family Leave continuation rights.

ii. Life and Accident Insurance – Unless otherwise specified by the terms of the plan or required by law, technicians on FML shall continue their core life insurance and may continue their optional life and accident insurance coverage at active employee rates during the FMLA.

iii. Retirement –Vesting, eligibility and benefit accrual service credit in the Continental Airlines Retirement Plan (CARP) shall be governed by the terms of the CARP unless otherwise required by law. No such service shall accrue during a FML, unless the technician is on a paid status (i.e., paid sick leave or vacation).

d. Employees ordinarily must provide thirty (30) days advance notice of intent to take Family and Medical Leave when the leave is foreseeable.

e. Employees granted Family/ Medical Leave must use any paid time off they may have (sick leave, vacation, deferred holidays, etc.) for their own serious health condition, a pregnant employee, or an employee giving birth.

f. Employees granted Family/ Medical Leave for eligible family members must use paid time off such as vacation, and deferred holidays, and sick leave but not sick leave unless required by law.

g. Seniority continues to accrue while on approved FML.

12. Military Leaves of Absence and Veterans' Re-employment Rights

a. Eligibility for Leave - A Military Leave will be granted to an employee in the following situations: i. An employee who leaves the service of the Company to enlist, or who is inducted into the Armed Forces of the United States for a regular tour of duty.

ii. An employee who is a member of a reserve unit of the military including National Guard units ordered to active duty.

iii. An employee whose probationary period has not ended will be eligible for military leave.

b. Duration of Leave - A military leave of absence will be granted for the duration of the employee's active service in the Armed Forces not to exceed five (5) years. The leave may continue for a maximum of 90 days from the date the employee is discharged from active service or from hospitalization continuing after discharge. The employee must apply for reinstatement within the 90 days. The maximum amount of military leave allowed is five (5) years or as soon after the expiration of five (5) years as the employee is able to obtain orders relieving him from active duty, (unless such five (5) year period has been extended by law.) Exception:

A reservist or guardsman who leaves his/her position for periods of training duty must apply for reinstatement within 31 calendar days after release.

c. Procedure for Obtaining Military Leave

i. An employee who receives notice of induction or orders to report for duty should immediately advise the employee's supervisor in writing of the effective date of the leave and the last day of work.

ii. The supervisor will give the employee written approval.

d. Effect of Military Leave on Employee Benefits

i. Company Service, Pay Seniority and all other seniority will continue to accrue as if employment were not interrupted.

ii. Employees will retain existing sick and occupational injury banks but will not accrue or acquire additional sick or occupational injury credit during the term of unpaid military leave.

iii. Vacations an employee has earned but not taken before receiving notice of induction or call to active duty need not be taken prior to military leave, in which case they will be available to the employee upon his return to work. Alternatively, an employee who does not take vacations before his leave may choose to be paid for the unused vacation time.

a) During active military service, vacations will continue to accrue in the same manner as if the employee had remained in active employment.

b) Subject to Department Head approval, reinstated employees may use any vacation earned for that calendar year at anytime after thirty (30) days of active reemployment. The Department Head may waive this thirty (30) day restriction for the convenience of the Company, or may elect to pay the employee for his vacation.

iv. Benefits

a) Medical/Dental/Vision - The Company shall continue to provide medical, dental and vision coverage on the same terms conditions as apply to an active technician (i.e., as if the technician were continuously employed) for technician's on military leave through the end of the twelfth (12th) month following the month in which the military leave began, and shall reinstate health care coverage on the day following the termination of military leave. Following the expiration of that twelve (12) months, medical, dental and vision coverage may be continued at the technician's expense at the same rate as the COBRA rate for the duration of the military leave, subject to plan changes and availability. In the event of termination of employment while on military leave, such coverage may be continued at the technician's expense using COBRA eligibility at the COBRA rate for the COBRA period provided by law (currently eighteen (18) months) following the last day of the month in which termination of employment occurred, subject to plan changes and availability.

b) Life and Accident Insurance – Current life and accident insurance coverage shall be continued through the end of the month in which the military leave begins on the same terms and conditions as apply to an active technician. Thereafter, unless otherwise specified by the terms of the plan or required by law, technician's on military leave may continue all or a portion of their current life and accident insurance coverage if so allowed by the individual life insurance company provider. The Company shall provide written notice regarding the technician's continuation responsibility and contact information for the life insurance provider at the time the military leave is granted. Continuation will be at the technician's expense and must be arranged by the

technician directly with the individual insurance company. The premiums for life and accident insurance continuation will be based on conversion rates.

c) Retirement – Vesting, eligibility, and benefit accrual service credit in the Continental Airlines Retirement Plan (CARP) shall be governed by the terms of the CARP unless otherwise required by law.

d) Passes – Technicians on military leave and their eligible family members shall have online pass privileges at their active employee pass classification for up to two (2) years, subject to the normal terms and conditions for personal use passes. Emergency pass provisions shall be made in case of family emergencies regardless of the length of the military leave.

e. Employment Rights and Reinstatement Qualifications

i. After returning from a military leave of absence an employee who receives a general or honorable discharge will be eligible or reemployment. Unless Company circumstances have so changed as to make it impossible or unreasonable to do so, any employee granted a military leave will be reinstated under the following conditions:

a) He did not remain in the military service for more than five (5) years.

b) The position which was vacated was not temporary.

c) Military leave has not exceeded five (5) years or as soon after the expiration of five (5) years as the employee is able to obtain orders relieving him/her from active duty (unless such five (5) year period has been extended by law.)

d) He is still qualified and physically fit to perform the duties of the position vacated.

NOTE: If disabled while in the military to the extent of being unable to perform regular job duties, the employee will be entitled to work in another position which he can perform and, depending on the circumstances, may be paid his pre-disability base rate of pay even if that is more than the alternative job's regular rate of pay.

e) Application for reinstatement is made within the allowable period as stated in this chapter.

ii. Process of Reinstatement - The returning employee will be reinstated in his/her former position or one of like status and pay. The employee will be notified of the date to resume duties, the place where such duties will be performed and other necessary information.

iii. Wage and Salary on Reinstatement - The wage or salary of the returning employee will be the amount which would have been received had the employee remained continuously in the position.

13. Military Leave for Reservists and Members of the National Guard

a. Employees who are reservists or members of the National Guard must request a Military Leave of Absence for the period required to perform active duty for training or inactive duty training in the Armed Forces of the United States. The request does not have to be in writing.

b. Employee Responsibilities:

i. The request must state the dates required for the leave if known. If a drill schedule is available for a prolonged period of time, only one request is necessary. A copy of the drill schedule must be attached.

Example: If drills are scheduled on the second weekend of each month, the request must state that beginning on (date), leave is requested each second weekend until (date).

ii. Employees are expected to give as much notice as possible to their supervisors so that proper duty coverage can be arranged. If less than one (1) weeks' notice is given, employees may be asked to assist the Company by arranging to trade days and shifts or use their regular days off to the extent possible.

iii. The reservist or National Guard member does not need to have written training orders at the time of the request.

iv. After completing the military training or drill exercise, the reservist or National Guard member must report back to his regularly scheduled shift.

v. This leave will normally be unpaid, but with advance approval from the employee's supervisor, vacation time may be used or his schedule may be adjusted.

Example: An employee's schedule may be adjusted to accommodate his normal day(s) off with the scheduled assigned military day(s). (i.e.: Employee normally has Wednesday and Thursday off, he is assigned military duty on Saturday and Sunday, employee may work Wednesday and Thursday and take off Saturday and Sunday)

c. Initial Active Duty Training

When an employee first joins the National Guard or Reserve, he/she

usually undergoes initial active duty training (IADT). IADT is treated as

regular active duty for re-employment rights purposes with the following

exceptions:

i. Unless the IADT is greater than one hundred and eighty (180) days, after completing IADT, a United Continental employee must re-apply within thirty-one (31) days, rather than ninety (90) days as in the case of regular duty.

ii. The time spent in IADT does not count toward the five (5) year limitation on the regular active duty.

d. Management Responsibilities

i. Management will grant a leave of absence to a reservist or National Guard member for the period required to perform active duty for training (drills) in the Armed Forces of the United States. Employees are expected to give as much notice as possible, however the timing, frequency and duration of the military training are determined by the military authorities.

ii. Job rights are protected so long as the reservist or National Guard member receives orders for military training. iii. Management will not deny a promotion to United employee because of any obligation as a reservist or member of the National Guard.

iv. Employees will not be required to use earned vacation time for their military training.

v. The reservist or National Guard member will not lose Company Service time, bid or Pay Seniority as a result of the military absence.

IBT-Represented Employee Career Move Handbook

September 1, 2017

A Introduction

United (the "Company") is committed to helping you make a successful move to your new assignment. The IBT Career Move Handbook (the "Handbook") has been designed to give you a better understanding of the Company's relocation program, including expense reimbursement and relocation assistance. The Company will review your expenses to confirm that they are reasonable. Your cooperation in helping to control costs will be greatly appreciated.

This Handbook is a summary of the major aspects of the Company's relocation program. In case of conflict between this Handbook and the Collective Bargaining Agreement (the "Agreement") between the Company and the International Brotherhood of Teamsters (the "Teamsters"), the Agreement shall govern. We recommend that you read this Handbook carefully. Knowing the steps involved in arranging your Company-paid move will ensure a smooth transition to your new assignment.

B Eligibility

An IBT-represented employee is eligible for a Career Move once in his career, provided he is not on probation or returning form inactive status (Furlough, Illness Leave, etc.). A Career Move can only be used for a job transfer from an actAive status at one location to an active status at another location. Your new residence must be within 50 miles of your new work location—services will not be provided to a residence outside this distance.

C Initiating Your Move

C-1 Learn About Your New Location.

First complete a UPE-1682 form and Relocation Repayment Agreement (both forms are included in this document as the last two pages). Assistance with area counseling and home-finding services at your new location will be available once you have received authorization through NuCompass Mobility, the Company's designated Relocation Services Provider (the "RSP"). Many of the aspects of your move will be handled directly with the RSP. Should you have any disagreements or disputes with the RSP regarding covered expenses, your Relocation Consultant from NuCompass will escalate to United. Be sure you have received Company authorization as confirmed by NuCompass Mobility
for your move before incurring move-related expenses. NuCompass can assist with various aspects of your move. Services include:

• A personal Relocation Consultant to assist you through the relocation process
• Information regarding housing availability and costs, commuting distance and alternatives, quality of schools and school districts (where available), state/local taxes, climate, recreational opportunities, any additional information you may request; and
• Appointments with qualified real estate agents in your new location

C-2 Set Up A House-Hunting Schedule.

House hunting must be completed on your own time and is not on paid time. Upon request, the Employee Travel Center will issue one highest priority roundtrip, non-revenue space available pass for you and your spouse or Company-recognized domestic partner to learn more about the area and to look for a new home.

All reasonable expenses, including lodging, meals (not to exceed $50 per day per person) and transportation, will be reimbursed for a three-day, two-night house-hunting trip to your new location. You must submit

expenses in the manner required by the Company, along with receipts for lodging, transportation and babysitting. Receipts are required for all meal expenses if the amount requested for any one person exceeds $20 per day. If you expect to incur babysitting expenses, please consult the RSP before you make your babysitting arrangements. Authorized babysitting expenses are reimbursed under the Miscellaneous Expense Allowance.

C-3 Terminating Your Lease (for renters only).

If you are currently renting your primary residence,1 in your departure work location the Company will pay the expenses associated with lease termination, provided you:
• do not advise your landlord that the Company will assume your lease obligation
• get the best lease settlement you can and submit a copy of the lease agreement for reimbursement. Final lease termination arrangements should be in writing and, if possible, signed by the landlord or his/her authorized agent

D Reporting To Your New Assignment

D-1 Interim Living Expenses

Interim living expenses provide reimbursement for duplicate expenses incurred at your new Base that are necessary in order to work at your new location. They allow time to find an appropriate rental unit or close on the purchase of a new residence. Interim living expenses will be reimbursed only if your previous primary residence remains unsold or un-leased. For information on interim living expenses, which include relocating your eligible dependents, see the section below titled "Waiting on Movers at New Residence." Once you have been activated at your new work location, the Company will reimburse reasonable (as defined by Company Business Travel Policy) interim lodging, meals and laundry expenses for the first 90 consecutive days if you own your home at your former location, or for the first 30 consecutive days if you rent at your former location. You must follow the Company's business travel policies when requesting a hotel room. In some cases, the RSP can arrange for direct-billing when booking a hotel so that you do not have to pay out of pocket. Contact the RSP to determine if this service is available in your new work location.

D-2 Reporting Expenses

Report your expenses weekly via the NuCompass Navigator website. Receipts are required for lodging, meals and laundry in accordance with the company travel expense policy. (NOTE: Dry cleaning is not a moving related reimbursable expense.)

D-3 Waiting on Movers at New Residence

If you and your family arrive at your new location before the scheduled moving van, the Company will reimburse reasonable lodging, meal and laundry expenses until you can move into your new home. Reimbursement is limited to a maximum of seven days. You must make arrangements through the RSP before incurring any expenses. Receipts and supporting documents for expenses are required. 1 Your "primary residence" is the home or apartment owned or rented by you in your departure work location. If your primary residence is not the same as noted on your Employee Profile, the Company's Relocation Services Provider may request a copy of a lease, purchase contract, utility bills or other documents to verify continuous ownership and/or residency.

E Moving Your Household Goods

E-1 Moving Your Household Goods

The Company will arrange for a professional moving company to handle the shipment of your household goods. You will be provided with contact information for the selected moving company. Work with the moving company's representative to schedule your household goods survey, packing, loading, storage and delivery. The Company will pay for the following services associated with moving normal household goods: • Normal packing and necessary materials;
• Transportation of up to 25,000 lbs. of household goods to your new primary residence;
• One extra pick up at point of origin or one extra delivery at destination each within a fifty (50) mile radius;
• Normal appliance service, including wiring and plumbing modifications at the point of connection, required for disconnection and reconnection of your appliances;
• Storage at your destination for up to 120 days, if necessary;
• Warehouse handling;
• One warehouse access to household goods in storage, if needed;
• Delivery to your new residence;
• Normal unpacking and removal of packing materials;
• TV antenna or small satellite dish (i.e., Direct TV or like service) removal and installation (This does not include removal and installation in fringe areas where a special mast-type antenna or other special installations are used.);
• Disassembly and re-assembly of cable TV service if moved from former residence;
• Disassembly and re-assembly of children's swing sets (not set in concrete); and
• Disassembly and re-assembly of a pool table.
The Company will not pay for the following services:
• U-Haul, self-move, or employee-contracted moving services—unless specifically approved in advance by the company with cost estimates via your Relocation Consultant.
• Exclusive use of the moving van or expedited service;
• Partial delivery of household goods from the warehouse;
• Housecleaning or maid service at either your former location or new primary residence;
• Removal or installation of wall-to-wall carpeting, draperies and/or rods, waterbeds (unless drained and prepared for shipment), electrical fixtures, water softeners or similar items; (See the Miscellaneous Allowances section of this handbook for further information on alteration and installation of draperies and carpeting)
• Expenses for additional wiring or plumbing, removal or movement of any existing utility service, and replacement or repair of existing utility systems or appliances;
• Packing or transportation of boats, trailers, camping and utility trailers, motorcycles (the Company will, however, pay to move a motorcycle in lieu of an automobile), jet skis, snowmobiles, lumber, bricks, cement, cordwood, airplanes or airplane parts, household pets except as specified below), plants or any perishable items, or items which are not considered part of normal household goods or personal effects;
• Hobby/woodworking equipment or machine tools that are oversized and/or that require special moving services;
• Packing or transportation of automobiles included with your household goods;
• Waiting time, overtime, weekend or holiday service provided by the moving company.
• Disassembly or re-assembly of children's playhouses, portable swimming pools, hot tubs, utility sheds, fencing or items of a similar nature; and
• Removal, replacement or repair of any portion of your fixed house.

E-2 Insurance of Your Household Goods

The Company will provide full replacement value insurance on your normal household goods. The amount of any insurance settlement is not to exceed $7 per pound multiplied by your shipment weight. For example, the

maximum insurance settlement for a shipment of 10,000 pounds cannot exceed $70,000. Items of excess valuation such as artwork and antiques may require the purchase of additional valuation coverage at your expense. Jewelry and other high-value items are excluded from this insurance coverage. Please consult with the RSP should you have any questions regarding insurance coverage. It is important that you keep currency, jewelry, coin collections, legal documents, or similar documents of extraordinary value in your possession during your move or that you ship them via insured mail. The movers cannot accept liability for these kinds of items. If you have other costly items that do need moving services such as extraordinary value items e.g., valuables, precious goods, collectibles, antiques, clocks, artwork, furs, handicrafts, paintings, sculptures, watches and similar merchandise, then a prior professional appraisal is required if the value of those items exceeds $100 per pound. Obtaining this a professional appraisal prior to your move will avoid valuation disputes in the event of a claim. The appraisal cost is not reimbursable by United. These items must be specifically identified to the moving company according to their disclosure processes. You must declare the presence of valuable items to your household goods move estimator and provide the appraisal to your move coordinator prior to any moving services beginning.

E-3 Moving Estimates/Schedules

You will make an appointment with the moving company to come to your home and estimate the necessary packing materials and loading time for your move. Please advise the moving company of any unusual items you plan to move, fragile items requiring careful handling and items which will remain at the location. You should try to arrange packing/loading/unloading/unpacking days with the moving company that best meet your schedule. The Company will not pay an additional cost for waiting time, overtime, weekend or holiday service. If it becomes necessary to change your move date, please advise the moving company at least 48 hours in advance to make arrangements for alternate dates.
The Company will pay for moving expenses to a maximum shipment weight of 25,000 lbs. of household goods. If your shipment exceeds the weight limit, you will be responsible for the additional charges incurred from the excess weight. Note that summer is the busiest time of year for our partner moving services providers, and schedules can fill up quickly. If you anticipate needing to move between May 15th and September 15th, let your Relocation Consultant know as soon as possible. A proactive approach to setting up your move will increase the probability of securing the service schedule you need during this time of year.

E-4 Packing and Loading

The moving company assumes full responsibility for all articles they pack and will not be responsible for damage to items you pack, unless the damage is caused by their obvious negligence. Packing will be done professionally by the moving company, using new materials. Dangerous items such as flammable gases and liquids, or perishable items such as plants or food, should not be packed or shipped.

Do not ship important documents, jewelry, money or other irreplaceable items. Do not pack your uniform, employee identification badges, or passport. You or your representative must be present when your household goods are loaded for shipment. The moving van driver should take inventory of all items to be moved, accurately marking the contents of the boxes and noting the condition of your household goods. Sign and keep a copy of the inventory list. You will need the inventory list should you claim any damage or loss.

E-5 Shipping Your Automobile

Helpful Tips for Shipping Your Automobile(s):
• After you have completed the form(s) to initiate a move, and the move has been approved, an automobile transport company will contact you to schedule a transport date.
• Remove all personal belongings from your automobile.

• At time of automobile pick-up, you must sign an Inspection Report and/or other form(s) as required by the automobile transport company.
• Upon delivery, inspect the vehicle, record any damages and sign the Delivery Receipt. Do not let yourself be rushed to sign off on delivery. Delays in identifying damage make it difficult to ascertain the cause of the damage and may result in denial of damage claims. If your automobile pick-up or drop-off point is an air freight office, air freight personnel will not be responsible for the inspection of your vehicle.
• Your automobile(s) must be owned by you and in operable condition prior to transfer.
• Shipment of antique (classic) automobiles must have prior Company approval.
• Your automobile (except for antique/classic automobiles) will be insured for transit-related damage.

E-6 Delivery at Your New Residence

Upon delivery, the driver and moving crew will unload and unpack your houehold goods.

Helpful Tips for Safe Delivery of Household Goods:
• Check the goods delivered against the inventory list made by the moving van driver at the time of loading. It is your responsibility to account for all items listed, noting any damage or loss, and to verify that all items to be moved were loaded
• It is to your advantage to have the moving crew unpack your household goods, as it places responsibility for safe delivery of fragile articles with the moving company. The Company will not pay for deferred unpacking. You should sign and date the moving company's form for only the actual and total amount unpacked, as the Company will be charged accordingly. Do not sign a blank form because this can significantly impact your ability make a claim later for damaged or lost items.
• Packing materials that you do not want to keep should be removed by the moving crew. The Company will not pay for deferred removal of packing materials
• You and the moving van driver should check for any property damage that may have occurred to your primary residence after your household goods were unloaded from the moving van, and record any damage on the inventory list

• If you have your goods in storage, you should advise the moving company at least two weeks in advance of the date that you want your stored goods delivered. This will help to ensure your desired delivery date is met

E-7 Reporting Damaged or Lost Household Goods

If there are any damaged or missing household items, follow these steps:
1. Inform the driver that the loss or damage did occur.
2. The moving van driver must note any damage or loss on the inventory list.
3. Keep a copy of the inventory list, noting the missing items or type of damage and the item number(s) affected. You and the driver should both sign and date the inventory list.
4. Request Proof of Loss and Damage forms immediately from the moving company at your destination.
5. Complete the Proof of Loss and Damage forms and return them to the moving company, indicating the item numbers of the missing or damaged articles and the extent of the damage. Do not send your copy of the inventory list.

E-8 Shipment of Personal Effects by Company Aircraft

You may request one shipment (up to 750 pounds) of personal effects as space available Company material (COMAT) on Company aircraft.
Household effects being shipped COMAT or NRSA must be:
• Properly and securely packed
• Clearly labeled with your new Company address, and
• Delivered to the nearest Company air freight office
Your shipment is subject to the same packing, size, and weight restrictions as all other Company air freight. Valuable, perishable, or time-critical items should not be sent COMAT or NRSA. For safety reasons, dangerous goods may not be packed along with household items as part of the COMAT or NRSA authorization when moving. Restricted articles include, but are not limited to: acids, matches, lighter fluid, paints, flammable solids such as flares, flammable liquids such as paint and lacquer thinners, corrosive materials such as wet cell batteries, explosives such as fireworks or black powder, compressed gases, fire extinguishers, poisons and irritating or incapacitating sprays. Firearms can be sent COMAT or NRSA provided they are unloaded and declared. Call the air freight office if you have any questions.
Your COMAT or NRSA shipment is not covered by Company insurance.

E-9 Transporting Your Pets

Pets can be shipped via United's PetSafe ™ or similar service at employee-discounted rates. The costs of shipping will be reimbursed through the RSP. You may purchase a kennel (maximum of two) from the air freight office. The cost is reimbursable, provided the Company has not previously reimbursed you for the purchase of the kennel(s). Health certification and rabies tags, if required, should be documented before shipping your pets. Necessary health certification, rabies tags and any other costs incurred in transporting your pet(s) are not reimbursable. During certain periods of the year, and at certain locations, The Company may embargo the shipment of pets on Company aircraft. In these situations, you should work with the RSP to arrange alternate transportation of your pets. If suitable arrangements cannot be made, it will be your responsibility to secure transportation of your pets. In some cases, driving en route to your new location may be the only way to ensure the safe and timely transportation of your pets. For additional information regarding the shipment of pets please contact a Company Cargo representative.

E-10 Moving Mobile Homes

In lieu of shipping your household goods the Company may agree to move a mobile home if it is your primary residence. Prior approval is required. Arrangements must be made through the RSP. You must provide details indicating the make, model, year and size (length, width, height) of your mobile home. You are responsible for making sure that your mobile home is in road-worthy condition. If modifications to your mobile home are needed to facilitate its transportation or to comply with state or local laws, the Company will not be responsible for the cost. You are also liable for any necessary en route repairs to your mobile home.

E-11 Storage

If needed, the Company will pay for a maximum of 120 days of storage of your household goods at your new location. Storage at the point of origin is not normally reimbursed and requests for exceptions must be approved prior to incurring the expense. Upon the completion of 120 days of Company-paid storage, your goods may be kept in storage, but the related costs for storage, moving items out of storage, and insurance will be yours. Your household goods must be removed from storage prior to the expiration of the Company-paid move entitlement period. If you do not take delivery of your household goods from storage to a new primary residence prior to the expiration of the Company-paid move entitlement period, you must reimburse the

Company for all costs incurred in connection with moving your property except any house-hunting expenses. It is suggested that you not use your one Company-paid trip to access goods in storage unless it is absolutely necessary.

E-12 Completion of Company-Paid Move

A Company-paid move is "complete" once household goods, automobile(s) and personal effects are delivered to a new primary residence. Unless otherwise previously approved, the Company will not reimburse moving expenses incurred more than 12 months after your start date of work at your new location.

E-13 Paid-Move Miscellaneous Allowance

Reasonable miscellaneous expenses required by your move that are not specifically covered elsewhere in this policy or the Agreement may still be reimbursed by the Company. Your total miscellaneous allowance is capped at a maximum of $3,000, and is not intended to provide full reimbursement for every expense you may incur. If you are considering an item for miscellaneous reimbursement, you must obtain prior approval via NuCompass before incurring the cost. NuCompass will obtain appropriate approvals from United. Some miscellaneous expenses may require additional verification such as previous bills, receipts or a seller's listing agreement to show comparable charges. It is obviously impossible to list all potential miscellaneous items, but the following represents typical reimbursable miscellaneous expenses:

- Cost to initiate comparable utility service at your new primary residence (e.g., new service fees, hook-up fees)
- Unexpired portion of current automobile registration fees
- Driver's license fees (including dependents)
- Single payment of non-recurring sales, use, excise or title taxes on automobile(s) brought into a state imposing such taxes (normal registration or title fees in your new state are not reimbursable)
- Babysitting during house hunting with prior consultation of the RSP.
- Alteration and/or installation of drapes and carpeting if used in the former primary residence (carpet cleaning and maid service will not be reimbursed)
- Retuning of a piano
- Installation of TV antenna if moved from former primary residence
- Installation of a garage door opener if removed from former primary residence
- Mortgage prepayment penalty (security and damage deposits for rented property will not be reimbursed)

E-14 Mileage

If you drive to your new location, United will reimburse you the current company business policy rate (The IRS business mileage rate, $0.535 per mile as of 1 January 2017) based on driving the most direct route. Contact your NuCompass Mobility Consultant if you have questions about determining the most direct route. This mileage reimbursement is intended to address driving costs such as fuel, tolls and wear and tear on your vehicle, thus those costs will not be reimbursed separately. United will reimburse mileage and/or costs for up to two vehicles between driving and shipping. You may drive two vehicles, or ship two vehicles or drive one and ship one. You should utilize regular days off to the best extent possible to minimize time away from work.

F SETTLING IN

F-1 Expenses

Any expenses you may incur that are not specifically covered in this Handbook or in the Agreement (except miscellaneous expenses as described above) are non-reimbursable, unless they have been pre-approved by NuCompass Mobility prior to incurring the expense.

F-2 Income Tax

Reimbursement for many moving expenses is considered taxable income. The Company is required to report these expenses to the IRS as income to you. Some reimbursements are deductible or excluded from your income. For payments that are not deductible or excluded, the Company will "gross up" your income (i.e., pay the federal and state tax obligation for you). "Gross-up" calculations are calculated using only your United income. They do not reflect income from outside sources. Your "gross-up" payment is meant to offset the additional federal tax liability impact for move-related reimbursements, but does not necessarily preclude any personal federal tax liability resulting from
your company-paid moving expenses.

F-3 Policy Interpretation

This Policy is meant as an outline of your IBT Career Move relocation benefits. It should be assumed that services not expressly stated in this document are not provided by the company. Please study this policy carefully and consult with your Relocation Consultant should you have questions regarding your particular situation. You must obtain approval prior to incurring any specific expense not described in this policy that you intend to submit for reimbursement; United is not obligated to reimburse you for expenses you incur without prior approval. Ultimately, WHQHR/WHQLR will determine the interpretation of the policy and will obtain appropriate approval for exceptions.
Employees who receive benefits in contradiction to the policy are expected to reimburse the company for the assistance received in error.

IBT Represented Career Move - RELOCATION REPAYMENT AGREEMENT
THIS AGREEMENT is entered into by and between United Airlines, Inc., or Continental Airlines, Inc. (“United’) and Employee to relocate (“Employee.”) WITNESSETH: WHEREAS, United employs and in connection therewith has agreed separately to provide Employee with certain relocation benefits to absorb a portion of the cost of an IBT represented employee’s one-time Career Move relocation nearer to Employee’s place of employment for United. NOW THEREFORE, in consideration of the foregoing and other good and valuable consideration, the receipt of which is hereby acknowledged, United and Employee agree as follows:
1. If Employee resigns from employ of United, including retirement or accepting a voluntary early-out or voluntary transfer to another location before the passage of 24 months from the date of Employee’s Relocation, then Employee will repay to United a pro-rated portion of all relocation-related allowances and expenses paid to the Employee or paid on the Employee’s behalf and all expenses incurred by United in connection with relocation services provided to the Employee. This pro-ration will be based on the number of months elapsed since the completion of the move rounded to the closest month.
2. Employee will pay United such amounts in full within 30 days after United sends to Employee at Employee’s last
known address by U.S. mail, or any other reasonable means, an invoice for the amounts Employee must repay.
3. United will be entitled to collect any such principal or interest due by offset against any unpaid salary, vacation pay, or any other amounts due from United to Employee. United may also collect any such amounts due by any other legal means.
4. For the purposes of this agreement, the term “date of Employee’s Relocation” will be defined as the date of home sale or the completion of any service in the policy, whichever comes later.
5. Employee is expected to be present at work on all scheduled work days and will only be provided with reasonable Positive Space travel between old and new work locations for up to six months or until the move is complete, whichever occurs first. The provision of relocation services does not incur an obligation from the Company to provide assistance during or after relocation.

6. This Career Move is unique to IBT represented employees and may not be combined or in any way used in conjunction with any other Company-paid relocations or benefits.
7. This Career Move is provided to move the employee's belongings and family from the previous work location to the current work location.
8. By signing this document, Employee certifies that Employee has not previously used any part of a Career Move
and agrees not to request a subsequent career move.

IN WITNESS WHEREOF, United, through its authorized representative, and Employee have executed this Agreement as of the date first above written.
Employee Signature _____ Date _____
Printed Name _____ Employee Number _____
Departure Residence Address _____ Please Circle One Below:
_____ Homeowner Renter
Address, work location and Homeowner/Renter status are subject to verification and eligibility requirements.

Transfer and Moving Information

Company Request Transfers

See Instructions below for routing

CONDITIONS OF THIS MOVE ARE SUBJECT TO THE APPROVAL OF HUMAN RESOURCES – MUST BE COMPLETED BEFORE YOUR RELOCATION BEGINS.

Employee Name Employee ID Number
Effective Date of Transfer Last date at old location Report date to new location
Old Location Supervisor Information
Supervisor name Company Address Code Phone Number
New Location Supervisor Information
Supervisor name Company Address Code Phone Number
Employee Title – old location Company Address Code
– old location Employee Title – new location Company Address Code
– new location
Current Employee Information (old location)
Home Address – Number and Street
City, State and Zip Code
Home Phone No.
Cell Phone No:
Work Phone No.
E-Mail Address: E-Mail contact will expedite the authorization of the relocation
process
Please Circle or X Own _____ Rent_____
Transportation and Travel Time – if known.
Note: Paid days off and vacation days require new supervisor approval.
Transportation to new location:
Fly ___ Drive ___

Mileage, if driving Number of travel days eligible for expense reimbursement (distance divided by 400)
Number of regular days off enroute
Number of work days enroute (applies only if distance greater than 800 miles)

Number of vacation days enroute
Remarks: List any special arrangements that may be required or information that may be useful to Human Resources or your supervisors at your old or new locations.
Required information and approvals

Employee Signature Date
Supervisor Signature – old location OR new location Date
Human Resources Approval –provided in ESC
Approval Signature Date
Supervisor at departing location provide to employee, ensure this form is completed and returned to the appropriate location for authorization as listed below. Missing Data or incomplete forms will cause a delay in relocation processes.
When complete, submit as a case in United Service Anywhere (USAW) via ess-usaw.ual.com or on Flying Together on the Employee Services tab

APPENDIX 16-A1 – PLAN DESIGNS FOR CORE MEDICAL OPTIONS

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductibles	$300 single/ $600 family	$600 single/ $1200 family	$200 single/ $400 family	$2500 single only $5000 true family deductible	$5000 single only $10,000 true family deductible	$250 single/ $500 family	
HSA Seed Amount (pro- rated per paycheck)	NA		NA	$750 single / $1500 family		NA	
Medical Annual Out-of-Pocket (OOP) Limits	$2000 single/ $4000 family	$4000 single/ $8000 family	$1,500 single/ $3,000 family	$3000 single only $6000 true family maximum* (includes deductible and coinsurance)	$6000 single only $12000 true family maximum* (includes deductible and coinsurance)	$1,500 single/$3,000 family	
Cross Application Out-of-Network Deductibles and OOP to In-Network	Yes		NA	Yes		Single deductible and OOP Limit for In-Network and Out-of-Network	

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Office Visit PCP	$25 co-pay	Covered at 60% after deductible	$25 co-pay	Covered at 95% after deductible	Covered at 60% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Office Visit Specialist	$40 co-pay		$40 co-pay				
Preventive Services (comprehensive array; See Appendix 16-C)	100% preventive		100% preventive	100% preventive		100% preventive	
Laboratory, x-ray and diagnostic testing	Covered at 80% after deductible	Covered at 60% after deductible	Included w/office visit	Covered at 95% after deductible	Covered at 60% after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Hospital/Inpatient			Covered at 90% after deductible				
Outpatient Facilities/Surgical			Covered at 90% after deductible				
Urgent Care Center	$50		$50 co-pay				
Emergency Room	$200 flat copay, waived if admitted		$200 co-pay, waived if admitted			Covered at 80% after deductible	

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Out of Pocket Limit (2016 – as adjusted annually per Affordable Care Act limits)	$4,850 single/ $9,700 family		$5,350 single/ $10,700 family	Consolidated with medical out of pocket maximum		Retail: Consolidated with medical out of pocket maximum Mail Order: $5,350 single / $10,700 family	
Retail Generic Drugs	$10 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs		$10 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs	Covered at 100% after deductible		Covered at 80% after deductible. Mandatory Mail – Limit 3 retail fills for maintenance drugs	
Retail Brand Preferred Drugs	$30 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs- only if less expensive than retail		$30 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs- only if less expensive than retail	Covered at 95% after deductible		Covered at 80% after deductible. Mandatory Mail – Limit 3 retail fills for maintenance drugs	
Retail Brand Non-Preferred Drugs	$50 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs - only if less expensive than retail		$50 co-pay Mandatory Mail – Limit 3 retail fills for maintenance drugs - only if less expensive than retai	Covered at 95% after deductible		Covered at 80% after deductible. Mandatory Mail – Limit 3 retail fills for maintenance drugs	
Retail Drug Supply Limit	30 day supply		30 day supply	30 day supply		30 day supply	

	Core PPO Option		Core EPO Option	Core HDHP		Traditional Medical PPO	
PLAN DESIGN	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mail Order Generic Drugs	$25 co-pay		$25 co-pay	Covered at 100% after deductible (plan provides coverage for drugs that are allowed to be covered pre-deductible)		$30 co-pay (2016 rate – subject to 7% annual increase)	
Mail Order Brand Preferred Drugs	$75 co-pay		$75 co-pay	Covered at 95% after deductible		$95 co-pay (2016 rate – subject to 7% annual increase)	
Mail Order Brand Non-preferred	$125 co-pay		$125 co-pay	Covered at 95% after deductible			
Mail Order Drug Supply Limit	90 day supply		90 day supply	90 day supply		90 day supply	

APPENDIX 16-A2 – NETCARE GUAM HEALTH PLAN PLUS

	NetCare Guam Health Plan Plus	
PLAN DESIGN	**In-Network**	**Out-of-Network**
Annual Deductibles	None	$200 individual/ $600 family
Medical Annual Out-of-Pocket (OOP) Limits	$1000 individual/$3000 family	Not applicable (Out-of-network deductible and copays do not apply to OOP limits)
Cross Application Out-of-Network Deductibles and OOP to In-Network	Not applicable	
Office Visit PCP	$10 United/FHP clinic $15 other in-network physician	70% after deductible
Office Visit Specialist	$25	
Preventive Services (comprehensive array; See Appendix 16-C)	100% preventive	
Laboratory, x-ray and diagnostic testing	$10 United/FHP clinic $15 other in-network physician	
Hospital/Inpatient	90% after $100 copay	
Outpatient Facilities/Surgical	$100 copay	
Urgent Care Center	$10 United/FHP clinic $15 other in-network physician	

	NetCare Guam Health Plan Plus	
PLAN DESIGN	**In-Network**	**Out-of-Network**
Emergency Room	$75	
Prescription Drug Out of Pocket Limit (2016 – as adjusted annually per Affordable Care Act limits)	Combined with medical	
Retail Generic Drugs	$10 co-pay	
Retail Brand Preferred Drugs	$20 co-pay	
Retail Brand Non-Preferred Drugs	$40 co-pay	
Retail Drug Supply Limit	30 day supply	
Mail Order Generic Drugs	$20 co-pay	
Mail Order Brand Preferred Drugs	$40 co-pay	
Mail Order Brand Non-preferred	$80 co-pay	
Mail Order Drug Supply Limit	90 day supply	
Injectable Drugs	10% coinsurance	

APPENDIX 16-B – PLAN DESIGN FOR CORE DENTAL PLAN

Benefit Features	Core PPO Dental Benefits	
	In-network:	Out-of-network:
Annual Deductibles		
Individual	$50	$50
Family (2 members of family must each satisfy individual deductible)	$100	$100
Annual Benefit Maximum	$2,000	$2,000
Orthodontics Lifetime Maximum	$2,000	$2,000
Office Visit Copay	$0	$0
PREVENTIVE SERVICES and DIAGNOSTIC SERVICES		
Dental cleaning Topical Application of Fluoride, Sealants and Space Maintainers	100% Covered frequency may apply to these services	100% Covered frequency may apply to these services
MINOR RESTORATIVE SERVICES		
Fillings, Endodontics, Periodontics, Oral Surgery	Covered up to 80%; after deductible	Covered up to 80%; after deductible; Subject to reasonable and customary limits

Benefit Features	Core PPO Dental Benefits	
	In-network:	Out-of-network:
MAJOR RESTORATIVE AND PROSTHODONTICS		
Initial placement of Dentures or Bridges to one or more natural teeth which are lost while covered by the Plan. Inlays and Crowns (Porcelain or Stainless Steel)	Covered up to 50%; after deductible; frequency may apply to these services	Covered up to 50% after deductible; Subject to reasonable and customary limits; frequency may apply to these services
ORTHODONTICS		
Exams, X-Rays, Models, Appliances (Adult and Child)	Covered up to 50%; after deductible; frequency may apply to these services	Covered up to 50% after deductible; Subject to reasonable and customary limits; frequency may apply to these services

APPENDIX 16-C – PREVENTIVE SERVICES

Preventive Exams and Screenings – Adult Male	
Physical Exam	100% annually
Prostate-Specific Antigen (PSA)	100% annually
Lipid Panel	100% annually
Glucose Testing	100% annually
Colorectal Screening	100% annually
Complete Blood Count (CBC)	100% annually
Immunizations – Adult Male	
Tetanus Injections (with or without diphtheria)	100% as often as recommended by physician
Meningitis	100%
Herpes Zoster	100%
Influenza Vaccine	100% annually
Pneumococcal Vaccine	100%
Travel Vaccinations	100% as often as recommended by physician
Measles, Mumps, Rubella (MMR) for Adults	100%
Preventive Exams and Screenings – Adult Female	
Physical Exams	100%, one general and one well-woman exam annually
Lipid Panel	100% annually
Glucose Testing	100% annually
Colorectal Screening	100% annually
Chlamydia Infection Screening	100% annually
Mammogram	100% annually
Bone Density	100% annually
Pap Test	100% annually
Complete Blood Count (CBC)	100% annually
Immunizations – Adult Female	
Tetanus Injections (with or without diphtheria)	100% as often as recommended by physician
Meningitis	100%
Herpes Zoster	100%
Influenza Vaccine	100% annually
Human Papillomavirus (HPV)	100%
Pneumococcal Vaccine	100%
Travel Vaccinations	100% as often as recommended by physician
Measles, Mumps, Rubella (MMR) for Adults	100%

Preventive Exams and Screenings – Children Birth to 18 (Covered as Well-Child Care)	
Office Visits; Examinations Includes: • Physical and medical history • Height and weight • Head circumference (<1 year) • Ocular prophylaxis (at birth) • Hemoglobin (<1 year) • Preventive health counseling, injury prevention and education • Dental health • Subjective assessment of vision and hearing (0–4 years) • Vision and hearing screen (4–18 years) • Developmental screening (up to 4 years) • Blood pressure (>1 year) • Administration of immunizations as indicated below	100%, as often as recommended by physician up to age 2, annually as of age 2
Immunizations – Children Birth to 18 (Covered as Well-Child Care)	
Hepatitis B Series Hepatitis A Series Diptheria/Tetanus/Pertussis (DTaP) Adult Tetanus/Diphtheria (Td) Haemophilus Influenza (Hib) Series Influenza Vaccine Rotavirus Polio Series (IPV) Pneumococcal Conjugate (PCV) Measles/Mumps/Rubella (MMR) Chickenpox Vaccine (VZV)	100%, as often as recommended by physician
Human Papillomavirus (HPV)	100%
Travel Vaccinations	100% as often as recommended by physician

Teamster Privilege

The Teamster Privilege program offers benefits that extend above the benefits negotiated with your employer under your Teamster contract. These benefits are available to you and your family for as long as you are a union member. Visit www.teamster.org for more information

Below are the available options for Teamster members

Credit card	1 800-721-7821

Retiree Health Insurance and Discounts

Medicare Supplement Program	1 800-808-3239
Medicare Rx Drug Program	1 800-524-4173
Early Retiree Health Plan	1 800-808-3239
Prescription discounts	1 800-308-0374
Dental and Vision savings	1 877-570-4843

Credit Counseling Program 1 877-833-1745

Insurance

Accident Insurance	1 800 393-0868	
Life Insurance	1 800 393-0868	
Senior Life Insurance	1 800 393-0868	
Hospital Income Program	1 800 393-0868	
Auto Insurance	1 877 999-9596	
Homeowner/renters insurance	1 866 366-4607	
Mortgage and Real Estate	1 800 416-5786	
AT&T Wireless discount	1 800 897-7046	
Vacations		
Tours	1 800 590-1104	
Travel Agent Services	1 800 491-2838	

Everyday Savings

Avis	1 800 698-5685	IDB723700
Hertz	1 800 654-2200	ID205666
Budget	1 800 455-2848	IDV816100
Flowers	1 888 667-7779	
Computers	1 877 882-3355	IDPS16626766
Union-made Checks	1 888 864-6625	
Moving Van Discount	1 800 234-1159	
Legal Services	1 888 993-8886	

IAM policies

American Bankers Life Assurance Company Group Cancer Plan

1122 Quail Roost Drive, Miami, Florida, 33157-6596

(305) 253-2244 (800) 524-5298

Continental American Accident injury policy and riders

2801 Devine Street, Columbia, South Carolina 29205

(800) 433-3036