UNITED

Summary Plan Description

Retirees

Regular and Bridge medical

Inside

United Airlines Benefits Center
1-800-651-1007

United Airlines Retiree Medical Program (Retiree Bridge Medical and Regular Retiree Medical)

Section 1. Introduction

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

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

- This SPD, which includes a *Contact Information Sheet* attached as an Addendum showing the addresses, phone numbers, websites, and other information for the Program's claims administrators, insurance companies, and United Airlines Benefits Center ("UABC")

- The Annual Enrollment and/or retirement materials provided to you, which include information about which medical plan options are available to you

- The Plan's Website found at flyingtogether.ual.com > Employee Services > Benefits (for single sign-on) or at www.ybr.com/united, which includes:

    - *Frequently Asked Questions* regarding the benefit programs offered under the Plan, including this Program

    - Additional detailed schedules of benefits for the medical plan options offered under the Program

    - Electronic copies of the most recent SPD and attachments, including the most recently-updated *Contact Information Sheet*

- The Plan's governing documents and insurance policies/certificates, copies of which can be obtained by contacting the United Airlines Employee Service Center.

Coordination with Plan Documents and Additional Information

Unless otherwise mentioned, this SPD reflects the terms of the Plan that are applicable to individuals who are covered under the Program on January 1, 2015 (even if they retired earlier). Please read this entire SPD carefully so you will understand the benefits offered under this Program.

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

Section 2. Participation

If you are an eligible retiree and you were enrolled in active coverage immediately prior to retirement, you may participate in Retiree Bridge Medical or Regular Retiree Medical, as applicable. You may also enroll your eligible dependents, provided they were also enrolled immediately prior to your retirement.

Retiree Bridge Medical

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.

Regular Retiree Medical

Regular Retiree Medical provides the same coverage options as Retiree Bridge Medical, but you pay the full cost of coverage. The monthly contribution amount for each coverage tier under Regular Retiree Medical varies by retiree group and coverage option and will be communicated to you in connection with initial or annual open enrollment. In addition, you may contact the UABC to obtain your monthly contribution information.

NOTE: Certain employee groups covered under the Program, including management and administrative employees, are not eligible for Retiree Bridge Medical. These employee groups are only eligible for Regular Retiree Medical, as described above.

Section 3. Electing Coverage

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.

<u>NOTE</u>: 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.

Section 4. 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.

Continuation of Coverage

If coverage ends for your dependent because he or she is no longer an eligible dependent, he or she may elect coverage under COBRA until the earlier of (i) 18 months from the loss of coverage or (ii) the occurrence of one of the other coverage ending events in the list above (other than the occurrence of your death).

If you had Retiree Bridge Medical coverage, then upon your death, your eligible dependent(s) are eligible to continue medical coverage until such time as they subsequently lose coverage as a result of any other of the coverage-ending events described above.

If you had Regular Retiree Medical coverage, your surviving eligible dependents may elect coverage under COBRA. This coverage would continue until the earlier of (i) 36 months from the loss of coverage due to your death or (ii) occurrence of one of the other coverage ending events described above, other than the loss of eligible dependent status.

Section 5. Coverage Generally

Coverage Options

The medical plan options available to you are generally the same as those available to active employees in your employee group (subject to change from year to year). Depending on where you live, you may be eligible to elect an HMO option in lieu of other coverage options. For additional information regarding coverage options that may be available to you, please see your Annual Enrollment materials and the Plan Website, which includes detailed Schedules of Benefits for each coverage option.

Exclusive Provider or Preferred Provider Networks

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

Claims Administrator
Please consult the *Contact Information Sheet* for the address, phone number, website, and other information for the third-party administrator/claims administrator applicable to your medical coverage under the Plan.

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

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

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

For additional information regarding the prescription drug benefits available to you under each coverage option, please see the applicable Schedule of Benefits for your coverage option on the Plan's Website.

Section 6. Managed Care

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

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

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

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

Section 7. Covered Expenses and Exclusions

Generally

Each coverage option has a specific schedule for covered expenses and exclusions, as well as the list of preventive services that are covered at 100%. The term “covered expenses” means the medical expenses incurred by a retiree or dependent that are recognized as payable under the applicable coverage option, subject to certain exclusions. See the detailed schedules of benefits found on the Plan Website. Federal law requires that certain minimum "essential health benefits” be provided in accordance with one or more coverage benchmarks. Please contact the Plan Administrator for additional information regarding the benchmark(s) used under the Plan.

Emergency Services

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

Medical Necessity

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

Section 8. Maintenance of Benefits and Coordination of Benefits

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

Coordination with TRICARE

TRICARE is government sponsored health care coverage for military personnel on active or retired duty. The coordination of your benefits under TRICARE works differently from the rules governing coordination with another employer plan or Medicare. If you or your dependents are receiving benefits under TRICARE, generally TRICARE will be the secondary payer with respect to any benefit offered under the Plan. For more information on how TRICARE coordinates with this Program’s coverage, please consult your TRICARE handbook or contact the Employee Service Center.

Section 9. Eligibility Claims and Appeal Procedures

Claims and Appeals for Benefits

To obtain your benefits under the Plan, you may have to file a claim. The claims and appeals procedures applicable to medical claims are described in Section 10 below. You may contact the Claims Administrator, insurance company or HMO for the relevant benefit to obtain the proper claim forms or for any additional information you need.

Claims Relating to Eligibility to Participate or Enrollment

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

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

Appealing an Eligibility Claim Denial

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

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

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

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

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

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

Right to Reimbursement

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

Section 10. Benefit Claims and Appeals Procedures

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

Claims Relating to Eligibility to Participate or Enrollment

If you inquire as to your eligibility for coverage under the Program independent of a claim for benefits, your inquiry will be treated as an eligibility claim and will be decided in accordance with separate claims and appeals procedures described in Section 9 above. However, please note, a claim for medical services or treatment may be denied because you or your dependent did not satisfy the Plan's eligibility criteria. Such a claim (and subsequent appeal, if any) will be decided in accordance with the procedures described below for claims relating to benefits.

Claims Relating to Medical Services, Treatments, and Other Benefits

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

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

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

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

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

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

Submitting a Claim for Benefits

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

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

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

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

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

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

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

Types of Claims

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

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

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

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

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

Time Frames and Procedures for Initial Claim Decision

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

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

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

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

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

Improper or Incomplete Claim

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

Exam

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

Adverse Claim Determination

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

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

Access to Relevant Documents

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

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

Appeal Procedures

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

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

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

described below. A claimant may voluntarily agree to provide the Claims Administrator with additional time to decide an appeal.

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

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

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

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

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

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

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

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

Notice of Decision on Appeal

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

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

- the reason(s) for the adverse decision;

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

Improper or Incomplete Claims or Appeals

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

Second Level of Appeal

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

External Review

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

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

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

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

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

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

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

If the request is eligible for the external review process, the Claims Administrator will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying you, in writing, that the request for external review has been accepted. The notice should include a statement that you may

submit in writing, within ten business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Claims Administrator. The Claims Administrator may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the external review process will end.

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

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

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

- a general description of the reason for the external review, including information sufficient to identify the claim (including date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- references to the evidence or documentation considered by the IRO in reaching its decision;
- a discussion of the principal reason(s) for the IRO's decision;
- a statement that the determination is binding and that judicial review may be available; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Expedited External Review

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

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

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

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

Misstatements of Facts

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

Overpayments

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

Subrogation and Reimbursement

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

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

- **Right of Reimbursement.** Whether or not you or your dependent execute a reimbursement agreement, in the event that the Plan provides benefits under a coverage option under the Program, and you or your dependent recover a payment, either by settlement, judgment, no-fault automobile insurance statute or otherwise, from any third party, then you or your dependent must immediately reimburse the Plan for the full amount of any and all benefits paid in connection with the non-occupational illness or injury (reduced by any average discount percentage applicable to prescription drug benefits) up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of Injuries. This right provides the Plan with priority over any funds paid by a third party or insurer, without regard to whether you or your covered dependent has been made whole. If the recovery is for damages other than for Covered Expenses under the coverage option (such as pain and suffering) you or your dependent will still be required to reimburse the Plan first. The Plan has a lien on any such recovery in the amount of the benefits paid by the Plan.

- **Right of Subrogation**. Whether or not you or your dependent execute a reimbursement agreement, if the Plan pays for a Covered Expense for which another party was responsible, the Plan is subrogated to all of your or your dependent's rights of recovery against any party to the extent of the benefits provided. This means that the Plan shall also have a lien on any recovery from such third party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending

lawsuit to secure and protect its rights. The Plan's right of subrogation shall apply to the first dollar of any recovery obtained from the third party, even if the recovery obtained is less than the amount needed to make you whole. If the Plan is precluded from exercising its right of subrogation or chooses not to exercise that right, the Plan has discretion whether or not to pay benefits.

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

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

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

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

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

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

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

- **Equitable Lien and Other Equitable Remedies**. The Plan will have an equitable lien against any rights you or your dependent may have to recover the full amount of benefits paid by the Plan for Covered Expenses from any party, including an insurer or another group health program. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid benefits for Covered Expenses under a coverage

option prior to a determination that the Covered Expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the Company will be deemed to mean that such a determination has been made.

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

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

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

  - You or your adult dependents may not assign any rights to recover the amount of Covered Expenses from any party to any of your or your dependent's minor child or children without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to settlements or recoveries of decedents, minors and incompetent or disabled persons.
  - You may not make any settlement that reduces or excludes, or attempts to reduce or exclude, the benefits provided under a coverage option.
  - The Plan's rights described above cannot be defeated or reduced by the application of any "made-whole doctrine" or similar doctrine or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
  - You or your dependents may not incur expenses on behalf of the Plan in pursuit of its rights. Specifically, neither court costs nor attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right cannot be defeated by any so-called "fund doctrine," "common fund doctrine," or similar doctrine.
  - The Plan has the right to recover the full amount of benefits provided without regard to any claim of fault on the part of you or your dependent, whether under comparative negligence or otherwise.
  - The benefits under the Plan are secondary to any coverage under no-fault or similar insurance.
  - If you do not honor your obligations, the Plan will be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs and other expenses.

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

Limitation on Bringing Legal Action

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

Assignment of Benefits and Other Rights

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

Section 11. Plan Information

Plan Name and Number

United Airlines Consolidated Welfare Benefit Plan; 540

Plan Year

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

Plan Sponsor

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

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

Plan Administrator

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

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

Funding and Administration of the Plan

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

Amendment and Termination of the Plan

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

ERISA Statement of Rights

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

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

- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual financial report.

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied (through the appeal procedure) or ignored, in whole or part, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

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


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