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

Effective January 1, 2016

About This Guide

Envoy Air, Inc. (the "Company") provides you with a comprehensive benefits package designed to help you meet the health, life, accident, disability, and dependent care needs of you and your eligible family members. To help you make the most of those benefits, this Employee Benefits Guide (the "Guide" or "EBG") describes the provisions of the Group Health and Welfare Benefits Plan for Employees of Envoy Air Inc. and Its Affiliates (the "Plan") effective January 1, 2016.

This Guide provides a comprehensive overview of the benefits available under the Plan as well as limitations, exclusions, Deductible and Co-Insurance requirements. A detailed list of benefit types provided under the Plan, along with contact information, can be found in the chapter "Reference Information." The provisions of this Guide apply to eligible employees on the United States payroll, spouses, Company Recognized Domestic Partners, dependents, and surviving spouses who elect coverage of the Company, Eagle Aviation Services, Inc., and Executive Airlines, Inc. (collectively, the "Affiliates"). The provisions of this Guide do not apply to employees of Executive Ground Services, Inc. Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

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

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

Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and an insurance policy/evidence of coverage, or this Guide, the Plan Document controls. If the Plan Document is silent, then the Guide controls, except where the Guide refers to an insurance policy/evidence of coverage. If both the Plan Document and Guide are silent, the terms of the applicable insurance policy/evidence of coverage controls. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or insurance policy/evidence of coverage control when describing specific benefits that are covered or insurance-related terms. If there is any discrepancy between the online version and this Guide, then the benefits outlined in this Guide, plus the official notices of changes to the Plan, will govern. See the chapter " Reference Information" to determine whether a particular benefit is self-funded by the Company or fully insured by the insurer. In the event of a conflict between the Plan's provisions contained in this Guide and the provisions contained in any applicable collective bargaining agreement, the collective bargaining agreement shall govern in all cases with respect to employees covered by such agreement.

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

Only the Company or the Envoy Benefits Administration Committee ("EBAC") is authorized to change the Plan. From time to time, you may receive updated information concerning changes to the Plan. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment, or benefits of any kind.

Contents

Benefits at a Glance

The Plan will include the following benefits for 2016:

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

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

Type of Benefit	Self-Funded or Insured	Administrator or Insurer	Funding Mechanism
Long Term Disability	Insured	The Hartford	Employee Premiums
FLEXIBLE SPENDING ACCOUNTS (FSAs)			
Health Care FSA	Self-funded	Aon Hewitt	Employee Contributions
Dependent Day Care FSA	Self-funded	Aon Hewitt	Employee Contributions
CRITICAL ILLNESS	Insured	AllState	Employee Premiums
EMPLOYEE ASSISTANCE PROGRAM	Self-Funded	EAP Consultants, LLC	General Assets of the Company
LEGAL SERVICES	Insured	Metlaw/Hyatt	Employee Contributions

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

General Eligibility

Eligible Employees

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

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

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

If you do not enroll for coverage when you are first eligible for benefits, you will receive no coverage. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

For coverage requiring proof of good health, coverage becomes effective only after coverage is approved and your first contributions are paid by you through payroll deductions.

Shortly following the start of employment at the Company, you will be able to enroll online at the Benefits Service Center. For more information about enrollment, see *General Enrollment*.

Hours Worked Requirement for Fleet Service Clerks and/or Agents

Newly Hired Employees

Effective January 1, 2015, newly hired employees will be eligible to enroll in benefits after one month of employment and will continue to be eligible for benefits through the end of the year in which the second anniversary of their start date occurs. Thereafter, they will be treated as "ongoing employees" and their eligibility and contribution rates will be determined based on their Eligible Hours during the period from October 3rd to October 2nd of the preceding year (the "Look Back Period"). For example, a Fleet Service Clerk or Agent hired on March 3, 2015 will be eligible for benefits on April 3, 2015 and will remain eligible through December 31, 2017. The annual analysis of Eligible Hours performed prior to the annual enrollment occurring in fall 2017 will review the Eligible Hours credited from October 3, 2016 through October 2, 2017 to determine eligibility for coverage during 2018.

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

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

For example, a Fleet Service Clerk or Agent hired on August 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015 and 2016. In contrast, a Fleet Service Clerk or Agent hired on March 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015, and the rate for 2016 will be determined based on whether he/she was full-time or part-time based on a prorated number of hours worked from March 3, 2015 through October 2, 2015. In both examples, the Fleet Service Clerk or Agent's contribution rate for 2017 will be based on the Eligible Hours worked during the October 3, 2015 through October 2, 2016 Look Back Period.

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

Ongoing Employees

Effective with the Plan year beginning January 1, 2014, after the second anniversary of their start date, Fleet Service Clerks and Agents must have worked 800 or more Eligible Hours during the Look Back Period to be eligible for coverage under the Plan. For example, the annual analysis of Eligible Hours performed prior to the annual enrollment occurring in fall 2015 (for the 2016 calendar year) will review the Eligible Hours credited from October 3, 2014 through October 2, 2015. Any Fleet Service Clerk or Agent who meets the appropriate Eligible Hours requirement during the Look Back Period will be eligible to enroll in benefits during the annual enrollment period for coverage during 2016.

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

Hours Worked Requirement for Flight Attendants

Newly Hired Employees

Effective January 1, 2015, newly hired employees will be eligible to enroll in benefits after one month of employment and will continue to be eligible for benefits through the end of the year in which the second anniversary of their start date occurs. Thereafter, they will be treated as "ongoing employees" and their eligibility and contribution rates will be determined based on their Flight

Attendant Eligible Hours during the Look Back Period. For example, a Flight Attendant hired on March 3, 2015 will be eligible for benefits on April 3, 2015 and will remain eligible through December 31, 2017. The annual analysis of Flight Attendant Eligible Hours performed prior to the annual enrollment occurring in fall 2017 will review the Flight Attendant Eligible Hours credited from October 3, 2016 through October 2, 2017 to determine eligibility for coverage during 2018.

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

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

For example, a Flight Attendant hired on August 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015 and 2016. In contrast, a Flight Attendant hired on March 3, 2015 and classified as part-time will pay the part-time employee contribution rate for 2015, and the rate for 2016 will be determined based on the prorated number of Flight Attendant Eligible Hours credited from March 3, 2015 through October 2, 2015. In both examples, the Flight Attendant's contribution rate for 2017 will be based on the Flight Attendant Eligible Hours worked during the October 3, 2015 through October 2, 2016 Look Back Period. "Flight Attendant Eligible hours" are outlined in the applicable Collective Bargaining Agreement.

Ongoing Employees

Effective with the Plan year beginning January 1, 2014, after the second anniversary of their start date, Flight Attendants that worked between 350 and 539 Flight Attendant Eligible Hours during the Look Back Period, prorated in accordance with the applicable Collective Bargaining Agreement, will be eligible for Company-subsidized health benefits at the part-time employee contribution rate. Flight Attendants who worked 540 or more Flight Attendant Eligible Hours during the Look Back Period will be eligible for Company-subsidized health benefits at the full-time employee contribution rate. For example, the annual analysis of Flight Attendant Eligible Hours performed prior to the annual enrollment occurring in fall 2014 (for the 2015 calendar year) will review the Flight Attendant Eligible Hours credited from October 3, 2013 through October 2, 2014. Any Flight Attendant who meets the appropriate Flight Attendant Eligible Hours requirement during the Look Back Period will be eligible to enroll in benefits during the annual enrollment period for coverage during 2015.

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

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

Eligibility After Age 65

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

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

None of the following individuals are eligible to participate in this benefits program:

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

Dependent Eligibility

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

Medical Coverage

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

- Spouse,.

- Company-recognized Domestic Partners and their children are not eligible to participate in Flexible Spending Accounts. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).**
- Child under age 26. See "Determining a Child's Eligibility" below for who qualifies as a "child."
    - Step-children.
    - Legally adopted children.
    - Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.
- Incapacitated child age 26 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.

Coverage for an Incapacitated Child – Medical Coverage Only

An "incapacitated child" age 26 or older is eligible for continuation of coverage if all of the following criteria are met:

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

Dental and Vision Coverage

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

- Spouse, Company-recognized Domestic Partner or common law spouse. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).**

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

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

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

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

The term does not include any person who:

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

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

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

- Your natural child, adopted child or stepchild (including the child of a Company-recognized Domestic Partner) who is under age 25 and unmarried.

The term also includes:

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

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

The term does not include any person who:

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

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

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

- Spouse, Company-recognized Domestic Partner or common law spouse, not employed by the Company.

  Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Company-recognized Domestic Partner as defined by the Plan As of January 1, 2017, the Plan will no longer cover Domestic Partners and their children.
- Stepchild
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" in the Additional Health Benefit Rules section).
- Special Dependent, if you meet all of the following requirements:
  - You must have legal custody and legal guardianship of the child.
  - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support
  - You must submit a Special Dependent Statement**,** available under Health & Welfare forms on the benefits page on my.envoyair.com**,** to the Benefits Service Center and the Benefits Service Center must approve the form. (Complete and return the form to the Benefits Service Center, along with copies of the official court documents awarding you custodianship or guardianship of the child.) You must receive confirmation from the Benefits Service Center notifying you of its determination.

- The Benefits Service Center will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 30 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by the Benefits Service Center. If you submit the request after the 30-day time frame, the child will not be added to your coverage.

Parents and Grandchildren

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

Dependents of Deceased Employees

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

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

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Proof of Dependent Eligibility

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

Whether you:

- enroll dependents when you are first eligible to enroll in benefits, or
- enroll new dependents at annual enrollments, or

- enroll new dependents as the result of a Life Event,

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

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

Determining a Spouse, Common Law Spouse, or Domestic Partner's Eligibility

Throughout this Guide, the term "spouse" is used to refer to your legally married spouse (of the same or opposite sex spouse), as well as your eligible common law spouse or Company-recognized Domestic Partner unless Company-recognized Domestic Partners are addressed separately. Under current laws, a Company-recognized Domestic Partner's health care expenses may not be reimbursed from your Health Care Flexible Spending Account and expenses for the children of your Domestic Partner may not be reimbursed from your Dependent Day Care Flexible Spending Account, unless the Domestic Partner is your tax dependent.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

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

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

law marriage to each other. Although criteria vary by state, the following guidelines usually apply:

- The couple cohabitates for a specified period of time established by the state.
- The persons recognize each other as husband and wife.
- The persons hold each other out publicly as husband and wife.

- **Domestic Partners.** Company-recognized Domestic Partners are defined as two people in a spouse-like relationship who meet all of the following criteria:
  - Are the same gender
  - Reside together in the same permanent residence and have lived in a spouse-like relationship for at least six consecutive months
  - Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
  - Are not legally married to, or the common law spouse or Company-recognized Domestic Partner of any other person
  - Submit a complete and valid Declaration of a Domestic Partnership from the Company-recognized Domestic Partner Enrollment Kit.

Company-recognized Domestic Partners and their eligible dependent children ARE eligible to be covered under the following benefits:

- Out-of-Area, PPO 750, PPO 1500 and PPO 2500 Options
- Health Maintenance Organizations
- Dental Benefit
- Vision Insurance Benefit
- Accident Insurance Benefit
- Spouse Life Insurance Benefit

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Note on Health Care Flexible Spending Accounts: Under current laws, a Company-recognized Domestic Partner's health care expenses may not be reimbursed from your Health Care Flexible Spending Account and child care expenses for your Domestic Partner children may not be reimbursed from your Dependent Care Account, unless the Domestic Partner is your tax dependent.

Note on Tax Dependents: Unless your Domestic Partner and your Domestic Partner's Children are your tax dependents, the Company will be required to report the value of any medical coverage provided to them as additional wages on your Form W-2. Please see the Domestic Partner Enrollment Kit for further details. After reviewing the Company-recognized Domestic Partner Kit, if

you need additional information regarding benefits and privileges available to Company-recognized Domestic Partners, please contact the Benefits Service Center at 1-844-843-6869.

Special Rules that Apply to Employees Married to Other Employees

Employees Married to Other Employees

When two employees are married to each other, they are referred to as "Married Employees" for this section. Married employees have the option of being covered as: (1) two single employees, each with their own employee coverage, or (2) under one employee's Medical, Dental and/or Vision benefits as an employee and a dependent. Married employees may elect to be covered under one employee's benefits during Annual Enrollment or at the time of a qualified Life Event (if the qualified Life Event allows such a change). If one employee decides to be covered under the other employee as a dependent, the employee covered as a dependent spouse, will not receive the company provided AD&D and Basic Life insurance, which is automatically provided to employees enrolled as employees in medical coverage.

Change in spouse's employment: If one spouse ends his or her employment with the Company, the spouse who changes his or her employment is eligible for coverage as a dependent (if he or she waives coverage under the subsidiary's health benefits). However if an employee is discharged for gross misconduct not related to any existing health condition for which treatment was provided for under the Plans, benefits or medical benefit options or dental benefit, he or she cannot be covered as a dependent of the active employee.

Spouse not eligible for full benefits: During the one-month waiting period required to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits. If your spouse is working as a part-time employee, he or she may waive medical and dental coverage and be covered as a dependent under your coverage.

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

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

The actively working spouse may elect to:

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

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

- Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave

- Proof of good health may be required to re-enroll or increase optional coverages upon the employee's return to work.

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

Other Information

Eligible dependent children*:* If both spouses are covered under the Group Health and Welfare Benefits Plan, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise. Contact the Benefits Service Center at 844-843-6869 to change this requirement. Children cannot be covered under both parents' health benefits. See "Dependent Eligibility

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Contributions: If both you and your spouse are covered independently under the Group Health and Welfare Benefits Plan and select exactly the same medical or dental option at the same cost, your contributions will be adjusted to ensure you pay approximately the same for your total family coverage as you would if your spouse worked elsewhere. The savings will be divided equally and applied to both your paychecks.

Family deductibles: Family deductibles (described under "Key Features of the Medical Options" in the *Medical* section) apply if both employees choose the same medical option. If the parents choose different options, the family deductible applies to the employee covering the children and the individual deductible applies separately to the other parent.

HMO participation*:* If you and your spouse enroll in the same HMO, the entire family unit is covered under the male employee's name because of HMO administrative procedures. If the male spouse takes a Leave of Absence (LOA), coverage for the family unit transfers to the female spouse for the duration of the leave. Company-recognized Domestic Partners are eligible for HMO coverage.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

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

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

Flexible Spending Accounts: Deposits to the Health Care and Dependent Day Care Flexible Spending Accounts (see the *Health Care FSA* and the *Dependent Day Care FSA* sections) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one

spouse is making deposits to the account, claims must be submitted under that person's Social Security number. If you both make deposits, you may only contribute the maximum amount the law permits for a couple filing a joint tax return. You may not file claims for expenses incurred by a Company-recognized Domestic Partner or his or her dependents under your Flexible Spending Accounts according to federal law.

General Enrollment

New Employee Enrollment

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

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

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

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

Current Employees

Annual Enrollment

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

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

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

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

You must complete a Personal Health Application form from The Hartford within 30 days after the close of annual enrollment. For example, if during annual enrollment for the 2016 benefit year you elect to increase the amount of your employee term life insurance for 2016, you must submit your Personal Health Application form to The Hartford no later than 30 days after the annual enrollment period ends. If your statement is submitted more than 30 days after the close of annual enrollment, your application for this coverage will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for the coverage.

Please Be Aware of These Important Points:

The annual enrollment period occurs each fall.

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

Annual Enrollment

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

contact the Benefits Service Center for proof of eligibility requirements (see "Contact Information" in the *Reference Information* section).

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

Newly eligible employees who do not complete the enrollment process will not be enrolled in any benefits. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

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

Default Medical Coverage for Current Employees

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

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

Benefit	Default	Comments
Medical Benefit Option	PPO 750, PPO 1500, PPO 2500 and Triple-S HMO	If your current medical benefit option is not available in your location, you and your eligible dependents will be enrolled in the Out-of-Area option. Employees with a Puerto Rico address will default to the PPO 750 option, if the current plan is no longer available. **Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.**
Flexible Spending Account Benefits (Health Care FSA, Dependent Day Care FSA)	No coverage	Your FSA accounts will default to $0.00 unless you enter an amount.

Waiving Coverage

You may choose to waive coverage if you do not want to participate in the Plan. Please keep in mind that your dependents will not receive coverage unless you are covered. If you waive coverage, you

can enroll in coverage later in the year only if you experience a qualifying Life Event such as marriage, divorce or the birth or adoption of a child.

How to Enroll

Follow these steps to enroll before your enrollment deadline:

Step 1: Visit the Enrollment Center on my.envoyair.com

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

Step 2: Review your dependents

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

Step 3: Enroll

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

Coverage Levels

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

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

When Coverage Begins

If you enroll by the enrollment deadline, your selected coverage is retroactive to the date you are first eligible for benefits and your paycheck is adjusted as necessary. If you select an HMO and need medical care during this interim period, you must receive treatment from a network provider to receive network coverage. If not, you will have no coverage if enrolled in an HMO.

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

Paying for Coverage

Each year the Company reviews the benefit options offered to employees and the cost of each plan. Based on your employment status and the number of family members enrolled in your coverage, the Company pays a certain amount towards the cost of your benefits. Once you have completed one month of Company service, the Company pays a portion of the cost of your medical and dental coverage; you pay the remaining amount of the actual cost for providing these benefits. Your contributions are fixed premium obligations and you will not be entitled to any reduction or refund of your contributions (including, without limitation, applicable deductibles or co-payments) in the event that the claims experience of the Plan is more favorable than projected or the Plan receives any discount, refund, rebate, settlement or damages pursuant to an agreement with or settlement or judgment with or from an insurer, any medical provider or other organization or individual.

Company-Provided Benefits

All eligible employees are provided with basic benefits protection. These benefits include:

- **Medical Benefits.** You can choose from PPO 750, PPO 1500, PPO 2500, Out-of-Area or an HMO option (if available in your area). Your contributions fund a portion of the cost with the Company covering a portion of the cost.

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

- **Dental Benefit.** You contribute a portion of the contribution cost.
- **Basic Life Insurance** coverage based on 1 times your annual salary for benefits (if enrolled in medical)
- **Accidental Death and Dismemberment Insurance** of 1 times your annual salary (if enrolled in medical).
- **Vision Discount Program:** All employees who elect medical coverage will be offered this program(See *Vision Benefits*).
-

Note that the Vision Discount Program will no longer be offered on or after January 1, 2017.

Employee-Paid Benefits

In addition to these Company-provided benefits, you can select from a number of optional benefits for which you pay the full cost. These include:

- Vision Insurance
- Voluntary Term Life Insurance
- Voluntary Personal Accident Insurance
- Optional Short Term Disability Insurance
- Long Term Disability Insurance

- A Health Care Flexible Spending Account
- A Dependent Day Care Flexible Spending Account
- Critical Illness Insurance
- Legal Services

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

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

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

Taxation of Benefits

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

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

Type of Benefits	Before-Tax?	May Waive?
Medical Benefit Options (for employee and tax dependents) ▪ PPO 750 Option ▪ PPO 1500 Option ▪ PPO 2500 Option ▪ Out of Area Option ▪ Health Maintenance Organizations Option (HMOs)	Yes	Yes*
Medical Benefit Options (for non- tax dependents) ▪ PPO 750 Option ▪ PPO 1500 Option ▪ PPO 2500 Option ▪ Out of Area Option ***Health Maintenance Organizations Option (HMOs) Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.***	No	Yes*

Type of Benefits	Before-Tax?	May Waive?
Vision Insurance Benefit	Yes	Yes
Voluntary Term Life Insurance Benefit (below $50,000)	Yes	Yes**
Voluntary Personal Accident Insurance Benefit	No	Yes
Spouse Term Life Insurance Benefit	No	Yes**
Child Term Life Insurance Benefit	No	Yes
Optional Short Term Disability Insurance Benefit	No	Yes**
Long Term Disability Insurance Benefit	No	Yes**
Health Care Flexible Spending Account Benefit	Yes	Yes***
Dependent Day Care Flexible Spending Account Benefit	Yes	Yes
Critical Illness	No	Yes*
Dental Benefit Option	Yes	Yes*
Legal Services	No	Yes

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

** Requires proof of good health any time you increase your level of coverage or if you waive coverage and later decide to elect it.

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

When Coverage Ends

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

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

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

- The date this plan or benefit option terminates
- The last day for which your spouse's contribution has been paid
- The date he or she is no longer your spouse
- The date you are no longer eligible for this plan or benefit option

- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the plan or benefit option.
- The date your surviving spouse remarries
- For a Company-recognized Domestic Partner, 90 days after your death (**this will no longer apply as of January 1, 2017)**

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

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

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

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

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

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

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

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

FMLA for Airline Flight Crewmembers

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

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care

- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition

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

Unpaid Sick or Injury on Duty Leave of Absence

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

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

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

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

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

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

IMPORTANT: If you elect not to continue your benefits while on your leave, or if you fail to timely pay the required monthly contributions for coverage, your benefits will terminate for the duration of your leave of absence unless you are no longer eligible for coverage due to failure to satisfy the hours for Flight Attendants, Fleet Service Clerks, and Agents (e.g., if your leave crosses calendar years).

When you return to active status, you may reactivate most of your benefits; however, some benefits will require that you supply proof of good health in order to reactivate them (i.e., Long Term Disability Insurance, Optional Short Term Disability Insurance, and Voluntary Term Life Insurance).

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

Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

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

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

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

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

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days. The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Employee Policy Guide

Family Medical Leave of Absence (FMLA) or Military Leave

If your leave is an FMLA or military leave, special rules govern your rights to continue or resume your benefits, which are based on federal law.

During the first year (12 months) of an unpaid sick or unpaid injury on duty leave of absence, you may keep the same benefits you had while actively working. You are responsible for timely paying your share of the cost for coverage during your leave. After this 12-Month Period, your coverage ends, at that time you may elect continuation of coverage under COBRA. However, if you terminate your benefits during the 12-Month Period, when you return to active status you may reactivate your Medical, Dental and/or Vision benefits if you continue to satisfy the hours requirements applicable to flight, crew, and/or agents.

For a detailed description of each leave of absence, consult with your supervisor.

Life Events and Special Enrollment Rights: Making Changes During the Year

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

HIPAA Special Enrollment Rights – Medical Benefit Option Only

If you or your dependents declined coverage under the Medical Benefits Option because you or they have medical coverage elsewhere and one of the following events occurs, you have 30 days from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option. Effective January 1, 2017, you will have 30 days from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option.

- You and/or your dependents (including your Company-recognized Domestic Partner and the children of your Company-recognized Domestic Partner*) lose the other medical coverage because:
    - eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
    - the employer contributions to the other coverage have stopped.
    - the other coverage was COBRA and the maximum COBRA coverage period ends.
    - you and/or your dependents (including your Company-recognized Domestic Partner and the children of your Company-recognized Domestic Partner*) exhaust a lifetime maximum in another employer's health plan or in other health insurance coverage.
    - Your employer and/or your dependent's, including your Company-recognized Domestic Partner's, employer cease to offer health benefits to the class of employees through which you (or one of your dependents) have coverage.
    - You and/or one of your dependents (including your Company-recognized Domestic Partner and the children of your Company-recognized Domestic Partner*) were enrolled under an HMO or other group or individual plan or coverage arrangement that will no longer cover you and/or one of your dependents) because you and/or your dependent no longer reside, live, or work in its service area

Note that as of January 1, 2017, the Plan will no longer offer the Triple-S Salud HMO.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).

- You have a new dependent as a result of your marriage, declaration of a Company-recognized Domestic Partner*, your child's birth, adoption, or placement for adoption with you.

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

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

*** Please note as of January 1, 2017, the Plan will no longer provide coverage for Domestic Partners.**

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

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

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

Keep in mind that if you are adding dependent(s) to your benefits during this special enrollment period, you must submit proof that these dependents qualify as your eligible dependents, and proof of loss of Medicaid or CHIP coverage, or proof of eligibility for the state premium assistance (under Medicaid or CHIP). Proof that the dependents you enroll qualify as your eligible dependents includes

(but is not limited to) official government-issued birth certificates, adoption papers, etc., as described in the Proof of Eligibility Requirements.

Life Event

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

You must register the Life Event within 30 days of the event with the Benefits Service Center. You must submit proof of the dependent's eligibility to the Benefits Service Center within 31 days of the date the documentation is requested. Proof of eligibility cannot be submitted until you receive the request from the Benefits Service Center. **If you miss the 30 day deadline, your Life Event change will not be processed.** You will have to wait until the next Annual Enrollment Period to make changes to your benefits. Effective January 1, 2017, you will have **30 days** from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option.

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

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

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

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

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

- Any change in your cost for coverage applies on the date the change is effective. Catch-up contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.

- You cannot enroll your dependents for coverage if you are not covered.
- You may start or increase a Health Care Flexible Spending Account only if you have enrolled a dependent that was not previously covered. Starting or increasing either Life, Accident, or Disability insurance may require proof of good health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance. When you add Life or Accident Insurance, you must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations, and you can make beneficiary changes on the Benefits Service Center. Once you complete and submit the online **Beneficiary Designation Form**, it supersedes all previous designations.
- If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment Insurance that will be paid is your "default coverage." If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.
- You or your spouse may only increase your Life Insurance coverage by one level per year, with proof of good health.
- If you elect to enroll in any coverage requiring proof of good health, you must submit (postmarked) a completed, dated, and signed Personal Health Application from The Hartford within 30 days after your enrollment/election date. If your statement of health is not postmarked within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.
- If you plan to cover your Company-recognized Domestic Partner under your Life Insurance, you must submit The Hartford Affidavit of Company-recognized Domestic Partnership. This form is part of the Company-recognized Domestic Partner Enrollment Kit. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).**

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

Table of Life Events and Permitted Benefit Changes

This table describes the changes you may make when certain life events occur.

If…	Then, You Can…
You become eligible for Company-provided benefits	Enroll online through the Benefits Service Center.
You get married or declare a Company-recognized Domestic Partner (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children)).**	▪ **Medical Benefits Options:** Add coverage for your spouse and eligible dependents; stop coverage for a dependent or yourself. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum will not carry over to your new Medical Benefit Option**. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage, however this coverage applies to the employee only. ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your spouse and/or child, or increase or decrease existing employee coverage. ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You divorce or legally separate, ***Your Company-recognized Domestic Partner relationship ends, or*** ***You obtain a protective order*** (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children)).**	▪ **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for your spouse. Add coverage for yourself and/or your eligible dependents (dependent coverage may be subject to QMCSO—see "Qualified Medical Child Support Order" in the *Additional Health Benefit Rules* section). You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your spouse and/or child, or increase or decrease existing employee coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for yourself; stop coverage for spouse or child; increase or decrease existing employee coverage ▪ **Flexible Spending Accounts Benefits:** Start/stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You or your spouse becomes pregnant	▪ This does not permit you to make any changes in your benefit elections until the baby is born

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

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

If…	Then, You Can…
Your spouse, Company-recognized Domestic Partner or dependent dies (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children)).**	▪ **Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent. You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible dependent; increase or decrease existing coverage for you with proof of good health. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent or start or stop coverage for yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
Change in spouse's/Company-recognized Domestic Partner's employment or other health coverage ***OR*** ***spouse's/Company-recognized Domestic Partner's employer no longer contributes toward health coverage*** ***OR*** ***Your spouse's/Company-recognized Domestic Partner's employer no longer covers employees in your spouse's position*** (**Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (and their children).**	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse, your eligible dependent or yourself; stop coverage for your eligible spouse, eligible dependent or yourself. You cannot change benefit plans at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible spouse/Company-recognized Domestic Partner or eligible dependent in the applicable benefit option. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You and/or your eligible dependent(s) declined Company medical coverage because you or they had coverage elsewhere (external to Company), and any of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your eligible dependents in a Medical Benefits Option: ▪ Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) ▪ Employer contributions for the other coverage stopped ▪ Other coverage was COBRA and the maximum COBRA coverage period ended ▪ Exhaustion of the other coverage's lifetime maximum benefit ▪ Other employer-sponsored coverage is no longer offered ▪ Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible dependents no longer reside, live, or work in its service area ▪ You have a new dependent via your marriage, your child's birth/adoption/placement	You have 30 days from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you, unless it is a HIPAA special enrollment event (see "Life Events and Special Enrollment Events"). Effective as of January 1, 2017, you will have **30 days** from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you. **This event allows you to add medical coverage only.**

If…	Then, You Can…
for adoption with you **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).**	

If…	Then, You Can…
You or your dependent exhausts a lifetime limit in another medical plan ***You or your dependents were enrolled in an HMO or another arrangement that will no longer cover you due to your failure to live, work or reside in the arrangement's service area***	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

If…	Then, You Can…
You move to a new home address: ▪ Update your address online at my.envoyair.com ▪ Submit a revised W-4 form for payroll tax purposes. The form is available online at my.envoyair.com ▪ Contact other organizations such as the American Airlines Credit Union and C. R. Smith Museum directly to update your contact information ▪ Provide your new address and current emergency contact numbers to your supervisor, as well	▪ **Medical Benefits Option:** May select from medical options available in new location if you moved out of the service area to any area with different options available. Contact the Benefits Service Center for more information. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent; increase or decrease existing coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You become disabled	▪ **Notify:** Your supervisor and call The Hartford to initiate a disability claim (if enrolled) ▪ **Complete and submit:** Your claim for disability benefits
You take a leave of absence	▪ **You will receive:** A personalized Leave of Absence Worksheet from the Benefits Service Center when the Payroll Transaction Request (PTR) placing you on unpaid leave is processed. The worksheet lists your options during the leave, cost for benefits coverage, and the election deadline. ▪ **Your cost depends on:** The type of leave you are taking

If…	Then, You Can…
You return from an unpaid leave of absence	▪ **Medical and Dental Options and Vision Insurance Benefit:** Resume coverage. You cannot change benefit options at this time. ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage; increase or decrease existing employee coverage. ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.

If…	Then, You Can…
You change from part-time to full-time or full-time to part-time*	▪ **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time ▪ **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only ▪ **Long Term Disability Insurance Benefit:** Start or stop coverage; however, this coverage applies to the employee only ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent, or increase or decrease existing coverage ▪ **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage ▪ **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions ▪ **Critical Illness Plan**: Start or stop coverage for your spouse or yourself. ▪ **Legal Services Plan**: Start or stop coverage for your spouse or yourself.
You die	▪ **Continuation of Coverage:** Your dependents or Company-recognized Domestic Partner should contact your supervisor, who will coordinate with Envoy Survivor Support to assist with all survivor benefits and privileges. The Benefits Service Center will send information, including the election of Continuation of Coverage, if applicable.
Your Company-recognized Domestic Partner dies	▪ **Continuation of Coverage:** You will receive information about Continuation of Coverage through COBRA for the surviving children of your Company-recognized Domestic Partner, if you contact the Benefits Service Center as required below ▪ **Contact: The Benefits Service Center** within 30 days of your Company-recognized Domestic Partner's death to update your records and make the appropriate changes, if applicable, to your benefits coverage
You end your employment with the Company	▪ **Review:** When Coverage Ends within this Guide ▪ **Review:** The information you receive regarding Continuation of Coverage through COBRA ▪ **Contact: The Benefits Service Center** for information

If…	Then, You Can…
You transfer to another work group or subsidiary of American Airlines Group	**Contact:** Your supervisor, the Benefits Service Center, or the new subsidiary to determine benefits available to you and to make new benefit elections
Benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")	**Make changes to the applicable benefit coverage:** The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child	**Medical and Dental Options and Vision Insurance Benefit:** Start or add coverage for the dependent(s) and yourself. You cannot change benefit options at this time.
You, your spouse or your dependent enroll in Medicare or Medicaid	**Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for the applicable person. You cannot change benefit options at this time.
You or your dependent(s) lose Medicaid or CHIP coverage	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. If you are already enrolled in Medical, Dental, and Vision Options and are adding dependents, you cannot change medical or dental options at this time. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: No changes allowed at this time. ▪ **Legal Services Plan**: No changes allowed at this time.

If…	Then, You Can…
You or your dependent(s) become eligible for a state premium assistance program (under Medicaid or CHIP)	▪ **Medical, Dental, and Vision Options:** Add coverage for yourself and your dependents. You may change Medical Benefit Options; **however, your Deductible and Out-of-Pocket Maximum <u>will not</u> carry over to your new Medical Benefit Option**. ▪ **Voluntary Term Life Insurance Benefit:** No changes allowed at this time. ▪ **Voluntary Personal Accident Insurance Benefit:** No changes allowed at this time. ▪ **Flexible Spending Account Benefits:** You cannot start, stop, increase, or decrease Flexible Spending Account contributions. ▪ **Critical Illness Plan**: No changes allowed at this time. ▪ **Legal Services Plan**: No changes allowed at this time.

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

Special Life Event Considerations

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

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

Stepchild: You may add coverage for a stepchild if the child lives with you and you the employee, either jointly or individually, claim the stepchild as a dependent on your federal income tax return.

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

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

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

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

Benefit Coverage Affected by Life Events

Voluntary Term Life Insurance Benefit: You may only increase this coverage by one level per year with approved proof of good health.

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

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

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

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

Benefit Coverage Not Affected by Life Events

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

Medical Benefit Options: You may change Medical Benefit Options only if you relocate (see "Table of Life Events and Permitted Benefit Changes"). However, if you are enrolled in the PPO 750, PPO 1500, PPO 2500 or Out-of-Area Option, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in your new location.

Medical Benefits Overview

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

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

- PPO 750 Option
- PPO 1500 Option
- PPO 2500 Option
- Out-of-Area Option
- Health Maintenance Organization (HMO) Option (for Puerto Rico employees). This option will be eliminated as of January 1, 2017. **Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).**
- As described in more detail below, some Medical Benefits are not offered in all locations. Employees residing in Puerto Rico will have the choice between an HMO and the PPO 750, PPO 1500, or PPO 2500 Options until December 31, 2016. All other employees will be eligible to participate in the PPO 750, PPO 1500, and PPO 2500 Options. Employees residing in St. Thomas and St. Croix, USVI, will have the choice between the Triple-S Salud HMO and the PPO 750, PPO 1500 and PPO 2500 until December 31, 2016. As of January 1, 2017, employees residing in St. Thomas and St. Croix, USVI will no longer have the Triple-S Salud HMO option. This determination is based on whether your alternate address zip code falls within a PPO service area. Each year an analysis is done to be sure that each PPO service area provides reasonable access to physicians, specialists, hospitals, and pharmacies for our members. If you live within a PPO service area you have a choice of the PPO 750 Option, the PPO 1500 Option or the PPO 2500 Option. If you do not live within a PPO service area you will be eligible for the Out-of-Area Option. Refer to *General Eligibility* for details regarding eligibility for benefits, dependent coverage, and employees married to other employee

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

Out-of-Area Option

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

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

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

PPO 750, PPO 1500 and PPO 2500 Options

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

You may decide whether to use network or out-of-network providers each time you need care under the PPO 750, PPO 1500 and PPO 2500 Options. Under the PPO 750 Option, when you use a network provider, you pay only a copayment or 20% coinsurance after deductible for most services provided by a network provider (with the exception for preventive care). Under the PPO 1500 and PPO 2500 Options, you pay 20% coinsurance after satisfaction of the deductible for services provided by a network provider. A deductible is required for any coinsurance-based services under the PPO 750, PPO 1500, and PPO 2500 Options.

If you go to a provider who is not part of the network, you are still covered for eligible, medically necessary services, but at a lower level of benefits, called the out-of-network benefit level. At the out-of-network benefit level, you pay a higher deductible and higher out-of-pocket amounts. For most out-of-network services, the plan pays 60% and you pay the remaining 40% after you satisfy the deductible. You will also be responsible for any amount exceeding the out-of-network reimbursement fee(s) which are calculated based upon Medicare allowable amounts. The amount you pay in excess of the out-of-network reimbursement rate will not apply to your out-of-pocket maximum. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the

remainder of the year. Please be sure to take this into consideration if you are considering using an out-of-network provider.

Health Maintenance Organizations (HMOs)

HMOs provide medical care through a network of physicians, hospitals and other medical service providers. You must use network providers to receive coverage under the HMO. Your expenses, including prescription drugs and mental health care, are covered according to the rules of the HMO you select.

Most HMOs require you to choose a primary care physician (PCP) to coordinate your medical care and to obtain a referral from your PCP before receiving care from a specialist.

HMOs are offered only in Puerto Rico and St. Thomas and St. Croix USVI. HMOs offered in your area appear as options in the Benefits Enrollment Center on my.envoyair.com during enrollment. When you enroll in an HMO, you will receive detailed information directly from that HMO.

Please note that as of January 1, 2017, the Plan will no longer cover Domestic Partners (or their children).

Prescription Drug Coverage

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

If you participate in an HMO, contact the HMO for information about your prescription drug coverage.

How the Medical Options Work

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

Under the PPO 1500, PPO 2500, and Out-of-Area Options, you are required to satisfy an annual deductible before the plan begins paying a percentage of the eligible, medically necessary expenses (with the exception of preventive care). All of the Medical Options allow you to use any qualified licensed physician. When you use a network provider, you are not responsible for the difference between the billed fee and the network rate. See "Special Provisions," below for information regarding physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services.

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

responsible for the difference between the billed fee and the network contract rate. This should reduce your out-of-pocket costs.

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

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

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

Key Features of the Medical Benefits Options

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

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

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

Individual annual deductible: Your annual deductible under the Out-of-Area, PPO 750, PPO 1500 and PPO 2500 Options is the amount of Eligible Expenses you must pay each year before your medical option coverage will start reimbursing you for services subject to coinsurance. After you satisfy the deductible, your selected medical option pays the appropriate percentage of the allowed amount for eligible covered medical services. If you are enrolled in the PPO 1500 or PPO 2500 Options, please read the following section on Family Deductibles.

Family annual deductible: Under the PPO 1500 and PPO 2500 Options, if more than one person is covered, all covered individuals will be subject to the Family Deductible. In these instances, the Individual Annual Deductible will not apply to any covered family members. Covered expenses that are paid out-of-pocket for all family members will be applied to the Family Deductible. Once the Family Annual Deductible has been met, the Plan will begin to pay coinsurance for covered services. (If the employee is the only person covered under the PPO 1500 or PPO 2500 Option, then the Individual Annual Deductible will apply.)

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

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

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

- Under the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options, all amounts applied to the deductible, copayments, and coinsurance amounts, apply to the annual out-of-pocket maximum.

Pre-authorization: Call your Network/Claim Administrator (or HMO as applicable) in the following situations:

- To pre-authorize a surgery or hospitalization.
- If you are using out-of-network services, you must call your network and/or claims administrator to pre-authorize any surgery or hospitalization.
- If you need emergency care, you should contact your network and/or claims administrator within 48 hours after you receive initial care to ensure that your claim is processed at the in-network benefit level as soon as possible.
- **Injury by others:** If someone else injures you and this Plan pays a benefit, the Company will recover payment from the third party. (This practice is known as *subrogation*, which is described in more detail under "Claims" in the *Plan Administration* section.)

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

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

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

Medical Benefit Options Comparison

The following tables provide a summary of features under the PPO 750, PPO 1500, PPO 2500 and Out-of-Area Options. Benefits are available for Eligible Expenses that are medically necessary and within the usual and prevailing fee limits for the Out-of-Area Option.

The tables show the amount or percentage you pay for Eligible Expenses, and you pay any amounts not covered by the options. If you are covered under the PPO 750, PPO 1500, PPO 2500 or Out-of-

Area Options and you use hospital-based services or services that require coinsurance, you must satisfy the individual or family annual deductible before the option pays benefits for Eligible Expenses.

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

- The out-of-pocket maximum under the medical options applies to coinsurance amounts you pay (i.e., for hospital services, including inpatient and outpatient care and surgery) as well as flat dollar co-payments. The out-of-pocket maximum also includes deductibles, but it does not include amounts not covered, or amounts exceeding the usual and prevailing fee limits for out-of-network services.
- Visit your network and/or claims administrator website or call to determine if your physician is a network provider.

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

PPO 750 Option

Plan Features	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS		
Individual Annual Deductible	$750	$1,500
Family Annual Deductible*	$1,500	$4,500
Individual Annual Out-of-Pocket Maximum**	$4,950	$9,900
Family Annual Out-of-Pocket Maximum**	$9,900	$21,300
PREVENTATIVE CARE		
Annual Routine Physical Exam	$0	Not Covered
Adult Immunizations	$0	Not Covered
Pap Test	$0	40% coinsurance* if medically necessary: routine pap tests are not covered OON
Screening Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond-once every year)	$0	Not Covered
PSA Screening and Colorectal Screening (According to age guidelines – routine coverage begins at age 50)	$0	Not Covered
Well Child Office Visits and Immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	$0	Not Covered
MEDICAL SERVICES – All services must be medically necessary		
Primary Care Physician's Office Visit	$25 copayment	40% coinsurance*
Specialist Office Visit	20% coinsurance*	40% coinsurance*
TeleHealth/Doctors on Demand Effective January 1, 2017	$15 copayment	$0

Plan Features	In-Network	Out-of-Network
Gynecological Care Visit	$25 copayment	40% coinsurance* if medically necessary preventive care is not covered OON
Diagnostic Mammogram According to Age Guidelines, (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond – once every year)	$0 if part of office visit or at a non-hospital imaging center; otherwise 20% coinsurance*	40% coinsurance*
Prenatal Care	$0	40% coinsurance*
Pregnancy – Delivery by Obstetrician	$350 copayment Effective January 1,2017 20% coinsurance*	40% coinsurance*
Second Surgical Opinion	20% coinsurance*	40% coinsurance*
Urgent Care Center Visit	$50 copayment	40% coinsurance*
Chiropractic Care Visit	20% coinsurance* (max of 20 visits per year in-network and out-of-network combined per covered family member)	40% coinsurance* (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance*	Not Covered
Allergy Testing, Shots or Serum	$0 if administered in the physician's office. Deductible and coinsurance applies only if office visit is billed.	40% coinsurance*
Diagnostic X-ray and Lab	$0 if part of office visit or at a non-hospital imaging center. Otherwise, 20% coinsurance* after deductible.	40% coinsurance*
OUTPATIENT SERVICES – All services must be medically necessary		
Outpatient Surgery in Physician's Office	$25 copay PCP office; otherwise 20% coinsurance*	40% coinsurance*
Outpatient Surgery in a Hospital or Free Standing Surgical Facility (Including anesthesia and medically necessary assistant surgeon)	20% coinsurance*	40% coinsurance*

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

Plan Features	In-Network	Out-of-Network
Hospice Care	20% coinsurance* if performed at a hospital; $25 copayment per day if home care	40% coinsurance*
OTHER SERVICES		
Vasectomy (Reversals are not covered)	20% coinsurance*	40% coinsurance*
Tubal Ligation	$0	40% coinsurance*
Infertility Treatment (Including in-vitro fertilization)	Not Covered	Not Covered
Radiation Therapy	No cost if performed in a physician's office; 20% coinsurance* if performed at a hospital	40% coinsurance*
Chemotherapy	No cost if performed in a physician's office; 20% coinsurance* if performed in a hospital or freestanding facility	40% coinsurance*
Kidney Dialysis (If the dialysis continues more than 12 months, participants must apply for Medicare)	No cost if performed in a physician's office; otherwise 20% coinsurance*	40% coinsurance*
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance*	40% coinsurance*
Hearing Aids	$3500 allowable per hearing aid. Replacement allowed every 36 months. 20% coinsurance*	$3500 allowable per hearing aid. Replacement allowed every 36 months. 40% coinsurance*
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Inpatient Mental Health Care	20% coinsurance*	40% coinsurance*
Alternative Mental Health Center – Residential Treatment	20% coinsurance*	40% coinsurance*
Alternative Mental Health Care Center – Intensive Outpatient and Partial Hospitalization	20% coinsurance*	40% coinsurance*
Outpatient Mental Health Care Visit	20% coinsurance*	40% coinsurance*
Marriage Counseling	Not Covered	Not Covered
Detoxification	20% coinsurance*	40% coinsurance*

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

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

*Coinsurance applies once you have satisfied the deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.

Once the Out-of-Pocket Maximum has been met, co-pays are waived.

PPO 1500 Option

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

Plan Features	In-Network	Out-of-Network
Well Child Office Visits and Immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	$0	Not Covered
MEDICAL SERVICES – All services must be medically necessary		
Primary Care Physician's Office Visit	20% coinsurance*	40% coinsurance*
Specialist Office Visit	20% coinsurance*	40% coinsurance*
TeleHealth/Doctors on Demand Effective January 1, 2017	$40*	$0
Gynecological Care Visit	20% coinsurance*	40% coinsurance* if medically necessary preventive care is not covered OON
Diagnostic Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond – once every year)	20% coinsurance*	40% coinsurance*
Prenatal Care	$0	40% coinsurance*
Pregnancy – Delivery by Obstetrician	20% coinsurance*	40% coinsurance*
Second Surgical Opinion	20% coinsurance*	40% coinsurance*
Urgent Care Center Visit	20% coinsurance*	40% coinsurance*
Chiropractic Care Visit	20% coinsurance* (max of 20 visits per year in-network and out-of-network combined per covered family member)	40% coinsurance* (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance*	Not covered
Allergy Testing, Shots or Serum	20% coinsurance*	40% coinsurance*
Diagnostic X-ray and Lab	20% coinsurance*	40% coinsurance*
OUTPATIENT SERVICES – All services must be medically necessary		

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

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

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

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

Plan Features	In-Network	Out-of-Network
Hospital Preauthorization (See Prior Authorization)	Required before hospitalization and recommended before outpatient surgery. Call BCBS for more information.	Recommended before hospitalization and surgery for all plans, for network and out-of-network. Call BCBS for more information.

*Coinsurance applies once you have satisfied the deductible. Coinsurance amounts (Medical and RX) apply towards the out-of-pocket maximum.

**If more than one person is covered, the family deductible must be satisfied before coinsurance applies.

***If more than one person is covered, the family OOP maximum must be met before receiving 100% coverage. In general, an individual will not be required to pay more than the Affordable Care Act's out of pocket maximum for self-only coverage in 2016 ($6,850) unless an individual changes benefit options mid-year pursuant to a HIPAA special enrollment right.

****Certain Preventive medications bypass the deductible; however copays/coinsurance still applies.

PPO 2500 Option

Plan Features	In-Network	Out-of-Network
DEDUCTIBLES/MAXIMUMS		
Individual Annual Deductible *(If more than one person is covered, the individual deductible will not apply)*	$2,500	$5,000
Family Annual Deductible** *(If more than one person is covered, the individual deductible will not apply)*	$5,000 True Family Deductible	$10,000 True Family Deductible
Individual Annual Out-of-Pocket Maximum** (If more than one person is covered, the individual Out-of-Pocket maximum will not apply)	$6,450	$12,900
Family Annual Out-of-Pocket Maximum** (If more than one person is covered under this option, the Family Out-of-Pocket Maximum applies to all members of the family.)	$12,900**	$25,800**
PREVENTATIVE CARE – All services must be medically necessary		
Annual Routine Physical Exam	$0	Not Covered
Adult Immunizations	$0	Not Covered
Pap Test	$0	40% coinsurance* if medically necessary: routine pap tests are not covered OON
Screening Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond-once every year)	$0	Not Covered
PSA Screening and Colorectal Screening (According to age guidelines-routine coverage begins at age 50)	$0	Not Covered

Plan Features	In-Network	Out-of-Network
Well Child Office Visits and Immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	$0	Not Covered
MEDICAL SERVICES – All services must be medically necessary		
Primary Care Physician's Office Visit	20% coinsurance*	40% coinsurance*
Specialist Office Visit	20% coinsurance*	40% coinsurance*
TeleHealth/Doctors on Demand Effective January 1, 2017	$40*	$0
Gynecological Care Visit	20% coinsurance*	40% coinsurance* if medically necessary preventive care is not covered OON
Diagnostic Mammogram According to Age Guidelines (Age 35 thru 39-one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond – once every year)	20% coinsurance*	40% coinsurance*
Prenatal Care	$0	40% coinsurance*
Pregnancy – Delivery by Obstetrician	20% coinsurance*	40% coinsurance*
Second Surgical Opinion	20% coinsurance*	40% coinsurance*
Urgent Care Center Visit	20% coinsurance*	40% coinsurance*
Chiropractic Care Visit	20% coinsurance* (max of 20 visits per year in-network and out-of-network combined per covered family member)	40% coinsurance* (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance*	Not covered
Allergy Testing, Shots or Serum	20% coinsurance*	40% coinsurance*
Diagnostic X-ray and Lab	20% coinsurance*	40% coinsurance*
OUTPATIENT SERVICES – All services must be medically necessary		
Outpatient Surgery in Physician's Office	20% coinsurance*	40% coinsurance*